Supreme Court, U.S.
FILED

08-543 OCT 21 2008

OFFICE OF THE CLERK
William K. Suter, Clerk

109 ①

No. ______

In the Supreme Court of the United States

LAWRENCE R. POLINER, M.D.,
LAWRENCE R. POLINER, M.D., P.A.,
Petitioners,

v.

TEXAS HEALTH SYSTEM, doing business as
Presbyterian Hospital of Dallas Texas, a Texas
non-profit corporation, JAMES KNOCHEL, M.D.,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

PETITION FOR WRIT OF CERTIORARI

MICHAEL A. LOGAN
KARIN M. ZANER*
KANE RUSSELL COLEMAN & LOGAN PC
3700 THANKSGIVING TOWER
1601 ELM STREET
DALLAS, TX 75201
(214) 777-4200

**Counsel of Record*
Counsel for Petitioners

October 21, 2008

Becker Gallagher · Cincinnati, OH · Washington, D.C. · 800.890.5001

QUESTIONS PRESENTED

The Healthcare Quality Improvement Act of 1986, §402 et seq., 42 U.S.C. §§ 11101 et seq. (2000) ("HCQIA") establishes limited immunity from money damages for professional review actions taken (1) in the reasonable belief that the action was in furtherance of quality health care, (2) after a reasonable effort to obtain the facts of the matter, (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirements of paragraph (3). A professional review action is presumed to have met these standards unless rebutted by a preponderance of the evidence. 42 U.S.C. § 11112(a) (2002).

The questions presented are:

1. Can a court exclude all evidence of subjective motives (an entire category of evidence) when it considers whether a defendant possessed a "reasonable belief" as required for HCQIA immunity under subsections (1) and (4), when such exclusion effectively:

    a) Usurps the fact-finding role of the jury?

    b) Renders state peer review immunity statutes meaningless?

c) Transforms the qualified immunity intended by Congress into absolute immunity?

2. What are the categories of evidence that can be considered in a court's determination of whether plaintiff's evidence is sufficient to rebut the statutory presumption?

PARTIES TO THE PROCEEDINGS BELOW AND RULE 29.6 STATEMENT

Petitioners Lawrence R. Poliner, M.D. and Lawrence R. Poliner, M.D., P.A. ("Poliner") were appellees in the court of appeals and plaintiffs in the district court. Petitioner Lawrence R. Poliner, M.D., P.A., is a Texas non-governmental corporation solely owned by Petitioner Lawrence R. Poliner, M.D. There is no parent corporation or publicly held company that owns 10% or more of the shares in Lawrence R. Poliner, M.D., P.A.

Respondents Texas Health Systems, a Texas Non-Profit Corporation doing business as Presbyterian Hospital of Dallas (the "Hospital"), and James Knochel, M.D. ("Knochel") (together "defendants") were appellants in the court of appeals and defendants in the district court.

TABLE OF CONTENTS

Pages

QUESTIONS PRESENTED i

PARTIES TO THE PROCEEDINGS BELOW AND RULE 29.6 STATEMENT iii

TABLE OF CONTENTS iv

TABLE OF AUTHORITIES vii

OPINIONS BELOW 1

JURISDICTION 1

STATUTORY PROVISIONS INVOLVED 2

STATEMENT OF THE CASE 3

REASONS FOR GRANTING THE WRIT 7

A. This disregard is a gross misapplication of evidentiary standards set by law, clearly hinders the administration of HCQIA, and serves as a compelling reason to grant certiorari. 8

B. The real facts of Poliner's case show the abuse of peer review. 10

C. The purpose stated by Congress shows that HCQIA immunity is qualified. 12

D. Congress used clear and plain language—"reasonable belief"—in the immunity standards. 14

E. Congress rejected broad immunity to avoid shielding anticompetitive behavior and other abuse when state immunity laws were avoided. 15

F. Congressional intent supports a more objective "reasonable belief" standard but in no way eliminates consideration of subjective intent. 17

G. Courts have transformed qualified immunity by wholly disregarding subjective intent. . 19

H. The resulting effects of the judicial misinterpretation clearly turn HCQIA on its head. 21

  1. Effect—There exists no evidence that can be used to rebut presumption of HCQIA immunity. 21

  2. Effect—Courts now routinely usurp the fact-finding role of the jury. 22

  3. Effect—Individual state laws are now rendered meaningless. 26

  4. Effect—Absolute immunity has resulted. 30

I. The stakes are high and the consequences serious—for physicians and patients. 32

J. Compelling reasons exist for the Court to stop the derailment of HCQIA. 33

CONCLUSION 34

APPENDIX

Appendix A: Fifth Circuit Opinion, dated July 23, 2008 . . . . 1a

Appendix B: District Court Amended Memorandum Opinion and Order and Judgment, dated October 13, 2006 . . . . 38a

Appendix C: District Court Order, dated July 7, 2004 . . . . 66a

Appendix D: District Court Memorandum Opinion and Order, dated September 30, 2003 . . . . 71a

Appendix E: Court's Charge to the Jury, dated August 26, 2004 . . . . 116a

Appendix F: Appellees' Brief, dated October 4, 2007 . . . . 163a

TABLE OF AUTHORITIES

Pages

CASES

Albemarle Paper Co. v. Moody,
422 U.S. 405 (1975) 30

Austin v. McNamara,
979 F.2d 728 (9th Cir. 1992) 11, 19, 24

Bakare v. Pinnacle Health Hosp., Inc.,
469 F.Supp.2d 272 (M.D. Pa. 2006) 22

Bogan v. Scott-Harris, 523 U.S. 44 (1998) 31

Briscoe v. LaHue, 460 U.S. 325 (1983) 31

Brown v. Presbyterian Healthcare Servs.,
101 F.3d 1324 (10th Cir. 1996) 20

Bryan v. James E. Holmes Reg'l Med Ctr.,
33 F.3d 1318 (11th Cir.1994) 25

Butz v. Economou, 438 U.S. 478 (1978) 31

Clinton v. Jones, 520 U.S. 681 (1997) 31

Cowett v. TCH Pediatrics, Inc.,
7th Dist. No. 05 MA 138,
2006 Ohio-5269 (Ohio App. 2006) 30

Fed. Trade Comm'n v. Am. Tobacco Co.,
274 U.S. 543 (1927) 9

Imbler v. Pachtman, 424 U.S. 409 (1976) 31

Imperial v. Suburban Hosp. Ass'n, Inc.,
37 F.3d 1026 (4th Cir.1994) 24

Islami v. Covenant Med. Ctr.,
822 F.Supp. 1361 (N.D. Iowa 1992) 25, 26

Mathews v. Lancaster Gen. Hosp.,
87 F.3d 624 (3d Cir.1996) 21

Meyers v. Columbia/HCA Healthcare Corp.,
341 F.3d 461 (6th Cir. 2003) 22

Nixon v. Fitzgerald, 457 U.S. 731 (1982) 31

Olsen v. Idaho State Bd. of Med.,
363 F.3d 916 (9th Cir. 2004) 31

Patrick v. Burget,
486 U.S. 94 (1988) 10, 17, 27

Pierson v. Ray, 386 U.S. 547 (1967) 31

Reeves v. Sanderson Plumbing Prods., Inc.,
530 U.S. 133 (2000) 10

Roe v. Walls Regional Hosp., Inc.,
21 S.W.3d 647 (Tex. App.—
Waco 2000, no pet.) 29

Spalding v. Vilas, 161 U.S. 483 (1896) 31

St Luke's Episcopal Hospital v. Agbor,
952 S.W.2d 503 (Tex. 1997) 29

Stump v. Sparkman, 435 U.S. 349 (1978) 31

Universal Camera Corp. v. N.L.R.B.,
340 U.S. 474 (1951) 9

Wahi v. Charleston Area Med. Ctr.,
453 F.Supp.2d 942 (S.D.W.Va. 2006) 22

Wieters v. Roper Hosp., Inc.,
58 Fed.Appx. 40 (4th Cir. 2003) 22

Zamaniam v. Christian Health Ministry,
No. 94-1781,
1994 WL 396179 (E.D. La. 1994) 27

CONSTITUTION

U.S. Const. Art. 3, Sections 1 and 2 1

STATUTES

Pub. L. No. 99-660, 100 Stat. 3743 (1986) 18

28 U.S.C. § 1254(1) (2000) 1

28 U.S.C. § 2101(c) (2000) 1

42 U.S.C §§ 11101 et seq. i

42 U.S.C. § 11101(1)-(3) (1995) 12

42 U.S.C. § 11101(4) 13

42 U.S.C. § 11101(5) 13

42 U.S.C. § 11111(a) 2, 3

42 U.S.C. § 11111(a)(1) 2

42 U.S.C. § 11112(a) (2002) . . . . i, 2, 18, 23, 24

42 U.S.C. § 11115(a) 16, 27

210 Ill. Comp. Stat. Ann. 85/10.2 (West 2003) . . . 28

225 Ill. Comp. Stat. Ann. 60/5 (West 2003) 28

Ala. Code § 6-5-333 (2006) 27

Ark. Code Ann. § 20-9-502 (2005) 27

Cal. Civ. Code § 43.7 (West 2003) 27

Cal. Health & Safety Code § 1370 (West 2003) . . 27

Conn. Gen. Stat. Ann. § 19a-17b (West 2003) . . . 27

Del. Code Ann. tit. 24 § 1768 (2003) 27, 28

Fla. Stat. Ann. § 766.101 (West 2003) 28

Ga. Code Ann. §§ 31-7-132, 31-7-141 (2001) 27

Haw. Rev. Stat. § 663-1.7 (2002) 27

Ind. Code Ann. §§ 34-30-15-15, 34-30-15-17 (West
2003) 28

Iowa Code Ann. § 147.135 (West 2003) 28

Kan. Stat. Ann. § 65-442 (2002) 28

La. Rev. Stat. Ann. § 13:3715.3 (West 2002) 28

Mass. Gen. Laws Ann. ch. 111, § 203 (2003) 28

Mich. Comp. Laws Ann. § 331.531 (West 2003) . . 28

Miss. Code Ann. § 41-63-5 (2003) 28

Mo. Ann. Stat. § 537.035 (West 2003) 28

Mont. Code Ann. § 37-2-201 (2002) 28

N.C. Gen. Stat. § 131E-95 (2003) 28

N.D. Cent. Code § 23-34-06 (2003) 28

N.H. Rev. Stat. Ann. §§ 329:17, 507:8-c (2002) . . 28

N.J. Stat. Ann § 2A:84A-22.10 (West 2003) 28

N.Y. Educ. Law § 6527 (McKinney 2003) 28

Neb. Rev. Stat. § 71-147.01 (2003) 28

Ohio Rev. Code Ann. §§ 2305.25, 2305.28
(West 2003) 28

Okla. Stat. Ann. tit. 63, §§ 1-1709, 1-1709.1 (West
2002) 28

Or. Rev. Stat. § 41.675 (2002) 28

Pa. Stat. Ann. tit. 63, § 425.3 (West 2003) 28

R.I. Gen. Laws §§ 5-37.3-7, 23-17-25 (2002) 28

S.C. Code Ann. § 40-71-10 (Law Co-op. 2003) ... 28

S.D. Codified Laws § 36-4-25 (2003) 28

Tenn. Code Ann. § 63-6-219 (2003) 28

Tex. Occ. Code Ann. § 160.010 (Vernon 2003) ... 28

Tex. Occ. Code Ann. § 160.010(a)(1)-(3) (Vernon 2001) 29

Tex.Rev.Civ. Stat. Ann. art. 4495b section 5.06(m) (repealed) 29

Utah Code Ann. §§ 58-13-4, 58-13-5 (2003) 28

Va. Code Ann. § 8.01-581.13 (Michie 2003) 28

Vt. Stat. Ann. tit. 26, § 1442 (2002) 28

Wis. Stat. Ann. § 146.37 (West 2003) 28

Wyo. Stat. Ann. §§ 35-17-103, 33-26-408 (Michie 2002) 28

RULES

Sup. Ct. R. 10(a) 8

Sup. Ct. R. 10(c) 9

OTHER AUTHORITIES

Black's Law Dictionary 106 (6th ed. 1991) 15

Black's Law Dictionary 164 (8th ed. 2004) 15

H.R. Rep. No. 99-903, at 1 (1986), *as reprinted in* 1986 U.S.C.C.A.N. 6384 .... *passim*

PETITION FOR WRIT OF CERTIORARI

Petitioners Lawrence R. Poliner, M.D. and Lawrence R. Poliner, M.D., P.A. ("Poliner") respectfully petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit.

OPINIONS BELOW

The published judgment of the district court awarding the jury verdict in favor of Poliner is available at 2003 WL 22255677 (N.D. Tex. Sep. 30, 2003) and is reprinted as Appendix 62a-65a.[1]

The Fifth Circuit's opinion reversing the district court's judgment is found at 537 F.3d 368 (5th Cir. 2008) and is reprinted as App. 1a-37a, with the portion pertaining to HCQIA immunity appearing at Appendix 16a-37a.

JURISDICTION

The Fifth Circuit issued its opinion on July 23, 2008. No motion for rehearing or rehearing en banc was filed by the parties. Pursuant to 28 U.S.C. § 2101(c) (2000), this petition was timely filed within 90 days after entry of the judgment by the Fifth Circuit. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1) (2000) and the United States Constitution, Article 3, Sections 1 and 2.

---

[1] "App." refers to the Appendix attached hereto.

STATUTORY PROVISIONS INVOLVED

Section 11111(a)(1) of Title 42 of the United States Code provides, in pertinent part:

If a professional review action (as defined in section 11151(9) of this title) of a professional review body meets all the standards specified in section 11112(a) of this title, except as provided in subsection (b) of this section –

(A) the professional review body,

(B) any person acting as a member or staff to the body,

(C) any person under a contract or other formal agreement with the body, and

(D) any person who participates with or assists the body with respect to the action,

shall not be liable in damages under any law of the United States or of any State (or political subdivision thereof) with respect to the action.

Section 11112(a) of Title 42 of the United States Code provides, in pertinent part:

For purposes of the protection set forth in section 11111(a) of this title, a professional review action must be taken –

(1) in the reasonable belief that the action was in furtherance of quality health care,

(2) after a reasonable effort to obtain the facts of the matter,

(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and

(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 11111(a) of this title unless the presumption is rebutted by a preponderance of the evidence.

STATEMENT OF THE CASE

Poliner, a board-certified interventional cardiologist with twenty years of experience, sued Knochel, the Hospital, and others for barring him from the cardiac catheterization lab using a sham medical peer review,[2] to falsely label him a dangerous doctor. Defendants knew these actions would eliminate his growing solo cardiology practice at the Hospital and ruin his unblemished reputation. Without the ability to work in the cardiac cath lab, Poliner's healthy, growing practice and referral base at the Hospital completely dried up. The peer review tool that Knochel and the Hospital used to suspend Poliner was called an "abeyance" under the medical staff bylaws. However, because Poliner did not consent to the requests for abeyance as required in the medical staff bylaws,[3] barring him from the cardiac cath lab took on the characteristics of a summary suspension.[4] Poliner claimed that the subsequent summary suspension imposed after the abeyance periods also wrongly labeled him a dangerous doctor. Due to the immediate impact to his practice at the Hospital along with the various third-party and self reporting obligations that are triggered when a peer review action takes place, these peer review actions caused Poliner significant

---

[2] Medical peer review is the evaluation of the qualifications and skills of physicians by the colleagues with whom they practice in order to monitor the quality, appropriateness, and necessity of the medical care given to patients. Every single person who receives medical care and their family members are touched in some way by this process. Legitimate, good faith medical peer review, which takes place every day in hospitals and health care facilities across

---

this country, is essential to the medical community and to patients.

[3] The jury clearly found that Poliner did not consent. *See* App. 125a-126a.

[4] Summary suspensions are typically reserved for situations where present and imminent harm exists. The false label, and thus, the defamation, emanates from the jury's finding that Poliner did not consent to the abeyance requests and was effectively summarily suspended. At trial, Knochel admitted that when he forced Poliner into the abeyance and the extension of the abeyance, he did not have enough information to determine that Poliner was a present danger to patients, which was required in order to properly impose a summary suspension under the medical staff bylaws. App. 197a.

damage and resulted in permanent black marks on his career and reputation. The jury agreed, finding defamation *per se* and awarding Poliner substantial sums in loss of earnings, injury to career and reputation, and mental anguish. App. 139a-145a.

The facts of Poliner's case are quite complex. App. 184a-202a. Poliner complained of three peer review actions taken against him by defendants: first, Knochel's threat on May 14, 1998 to immediately suspend Poliner if Poliner did not agree to an abeyance of his privileges in the catheterization lab (due to this threat, Poliner signed a letter "accepting" the abeyance); second, Knochel's threat on May 29, 1998 to immediately suspend Poliner if Poliner did not agree to extend the abeyance to June 12th (due to this threat, Poliner signed a letter "accepting" the extension); and third, Knochel's decision to summarily suspend all Poliner's privileges on June 12, 1998. App. 181a-182a.

After extensive discovery, defendants moved for summary judgment claiming immunity from damages under HCQIA and the Texas peer review immunity statute. App. 76a-77a. Poliner responded with extensive summary judgment evidence showing defendants' actions were based on false and malicious criticisms of Poliner's work, were biased and pretextual, and were undertaken after woefully inadequate investigation, notice, and hearing. App. 182a. Despite this evidence, the trial court granted partial summary judgment on September 30, 2003, holding that the June 12 suspension met the standards for statutory immunity. App. 94a-106a. But the court also determined that fact issues existed as to whether the actions taken on May 14 and May 29 met the standards for immunity. App. 94a-106a. Subsequently, the court held that Poliner could not recover damages flowing from the June 12 suspension. App. 66a-70a.

Following a two-week trial that focused on the May 14 and May 29 actions taken by Knochel, the Hospital, and two other defendant doctors (Dr. Harper, chief of cardiology, and Dr. Levin, head of the cath lab), the jury unanimously found in Poliner's favor on every question submitted (App. 123a-162a), and made explicit findings that defendants acted with malice (App.132a-134a). Although the actual and exemplary damage figures in the verdict totaled over $366 million, Poliner recognized that the awards overlapped. Thus, he sought actual damages of approximately $70 million and exemplary damages of $90 million against Knochel and the Hospital (the other two defendants having settled). App. 183a. Defendants filed extensive post-trial motions. App. 38a-39a.

After considering defendants' motions, the trial court ruled that: (1) defendants waived a number of arguments by not raising them at trial; (2) sufficient evidence supported the jury's findings that defendants were not entitled to immunity; (3) sufficient evidence supported the jury's findings of contract breach, defamation, and tortious interference, and judgment would be rendered on the defamation claim; (4) there was sufficient evidence that damages awarded to Poliner resulted from the May actions (as opposed to the immune June 12 action); (5) defendants were not entitled to a new trial based on alleged trial errors or claims of jury passion and prejudice; (6) the awards of actual damages for injury to career/reputation and mental anguish were excessive and should be remitted to a total of $21 million; and (7) exemplary damages should be statutorily capped at $750,000 against each defendant. App. 38a-61a and 183a. Poliner accepted the remittitur (App. 183a-184a), and the trial court rendered an amended final judgment consistent with its opinions. App. 62a-65a.

Defendants appealed to the Fifth Circuit. On July 23, 2008, the Fifth Circuit reversed and rendered judgment in favor of defendants, holding they were, as a matter of law, immune from money damages under HCQIA. App. 1a-37a. In its ruling, the Fifth Circuit clearly refused to consider Poliner's evidence that his peer review was malicious and based on subjective motives unrelated to health care (anticompetitive and political motives and personal dislike). The Fifth Circuit, in applying the "objective reasonableness" test for determining immunity stated that "the good or bad faith of the reviewers is irrelevant." App. 22a. The Fifth Circuit made it plain that Poliner's claims of "bad motives or evil intent" and "anti-competitive motives" were completely disregarded in its "reasonable belief" analysis. App. 25a. The Fifth Circuit then concluded that HCQIA standards were met and granted defendants immunity as a matter of law. App. 16a-37a. Poliner petitions for certiorari.

REASON FOR GRANTING THE WRIT

This Court should grant certiorari because the Fifth Circuit, in deciding to grant HCQIA immunity as a matter of law, wholly disregarded subjective motivations (an entire category of substantial evidence) in direct contravention of statutory language and clear Congressional intent.

A. This disregard is a gross misapplication of evidentiary standards set by law, clearly hinders the administration of HCQIA, and serves as a compelling reason to grant certiorari.

The existing judicial interpretation of the "reasonable belief" standard concludes that evidence of subjective motivations is wholly irrelevant when deciding a question of immunity. This interpretation has directly caused the circuit courts of appeal (here, the Fifth Circuit) to sanitize the facts of these cases to disregard evidence of subjective motivations (such as anticompetitive and political motives and personal dislike). This flies in the face of what Congress intended by its clear and unambiguous use of statutory language as well as in supporting legislative history. As a result, judicial findings in case after case demonstrate that no set of circumstances can ever result in rebuttal of the "reasonable belief" standard in the first and fourth prongs of the immunity analysis. The existing interpretation of the "reasonable belief" standard thwarts the concept of limited immunity and instead confers absolute immunity.

There are compelling reasons for the Court to accept this case. Pursuant to Supreme Court Rule 10(a), the Court should take this case because the Fifth Circuit "has so far departed from the accepted and usual course of judicial proceedings . . . as to call for this Court's supervisory power." Further, according to Supreme Court Rule 10(c), the Court should grant certiorari because the Fifth Circuit "has decided an important question of federal law that has not been, but should be, settled by this Court."

Certiorari is appropriate when precedential decisions of the appellate courts as to the construction and interpretation of a federal statute might seriously hinder future administration of the statute. *See Fed. Trade Comm'n v. Am. Tobacco Co.*, 274 U.S. 543 (1927) (finding serious hinderance of future administration of the law was grave and sufficiently probable to justify issuance of writ, but ultimately controversy over FTC cease and desist order turned on a previously decided fact issue of no general importance). The Court also has power to review the correctness of judicial application of an evidentiary standard in the rare instance when the standard appears to have been misapprehended or grossly misapplied. *See Universal Camera Corp. v. N.L.R.B.*, 340 U.S. 474, 490-91 (1951) (correcting variant applications of the "substantial evidence" standard for reviewing evidentiary validity of NLRB findings and redefining the scope of judicial review of administrative actions).

As it stands, the Fifth Circuit completely disregards a precise category of evidence that Congress specified should factor into HCQIA immunity analysis. This constitutes a gross misapplication of the statute's express evidentiary standard. As a result, the Fifth Circuit and its sister circuits routinely usurp the jury's fact-finding role, render state immunity laws meaningless, and transform the qualified immunity carefully crafted by Congress into absolute immunity.

One can scarcely imagine a more serious hinderance to the future administration of HCQIA. This pressing conflict demands this Court's guidance.

B. The real facts of Poliner's case show the abuse of peer review.

Effective medical peer review is essential to the provision of quality medical care. *Patrick v. Burget*, 486 U.S. 94, 105 (1988). Poliner's case reveals an undeniable abuse of medical peer review for reasons unrelated to health care. Such abuse, if unchecked, can irreversibly harm or destroy the reputations and careers of physicians across this country. The decisions made in Poliner's peer review were tainted by anticompetitive and political motives and personal dislike-motives that Congress, in passing HCQIA, explicitly directed would be considered when reviewing the "reasonable belief" required under the immunity statute. The Fifth Circuit, by following the standards laid out by its sister circuit courts, has completely eliminated consideration of these subjective motives as irrelevant and immaterial. Poliner turns to this Court, for the sake of his profession, the health care system, and patients themselves, as the only authority that can restore the objective reasonableness analysis clearly intended by Congress.

The real and complete facts of Poliner's story are set forth in Appendix 184a-202a.[5] A careful review of these facts-the evidence that the jury actually believed-provides an understanding of the complex factual circumstances of Poliner's peer review. These facts paint a very different picture from the sanitized version of the facts set forth by the Fifth Circuit's reversal opinion. App. 3a-12a. These facts show the interwoven anticompetitive and political motives of the defendants and others involved in Poliner's peer review whose opinions were sought out and relied upon by defendants. These facts show the overwhelming evidence that Poliner was personally disliked by many of his reviewers, especially Knochel. These facts were accepted by the jury, which heard and weighed the evidence and made determinations about credibility. Above all, these are the facts that Congress specifically intended would factor into the determination of "reasonable belief" under the first and fourth prongs of immunity.

---

[5] All reasonable inferences are drawn in favor of Poliner and all evidence favoring defendants that the jury is not required to believe has been disregarded. *See Reeves v. Sanderson Plumbing Prods., Inc.*, 530 U.S. 133, 150-51 (2000).

The Fifth Circuit is forced by the judicial interpretation of its sister circuits to utterly ignore the standards for reviewing jury verdicts, as clearly shown by its selectively sanitized version of the facts. This is a direct result of the line of cases, starting with *Austin v. McNamara*, 979 F.2d 728 (9th Cir. 1992), holding that an entire category of evidence (evidence of "subjective motives") is wholly irrelevant to evaluating "reasonable belief." As a result, the Fifth Circuit fashioned a one-sided version of the events that creates the impression that Poliner was a dangerous doctor with whom Knochel dealt fairly and reasonably by letting him agree to short periods of "abeyance" of his cath lab privileges. The Poliner jury, however, unanimously rejected that misleading version of events, as they were absolutely entitled to do. When the evidence wholly disregarded by the Fifth Circuit is factored back in, the jury's findings that defendants did not have a "reasonable belief" are amply supported. Restoring the Fifth Circuit's ability (and, indeed, its obligation) to consider evidence of subjective motivations will remedy this gross misinterpretation of clear statutory language and Congressional intent. The Court must return the analysis to that originally envisioned by Congress, so that what is now effectively absolute immunity will operate as the qualified immunity Congress intended. Physicians, patients, and the healthcare system as a whole depend on it.

C. The purpose stated by Congress shows that HCQIA immunity is qualified.

In 1986, Congress enacted HCQIA after recognizing nationwide problems of medical malpractice and the need to improve the quality of medical care by restricting the ability of incompetent physicians to move from state to state without disclosure or discovery of previous damaging or incompetent performance. 42 U.S.C. § 11101(1)-(3) (1995). Congress decided these problems were best remedied through effective professional peer review. *Id.* The express purpose of enacting HCQIA was to "improve the quality of medical care by encouraging physicians to identify and discipline other physicians who are incompetent or who engage in unprofessional behavior." H.R. Rep. No. 99-903, at 1 (1986), as *reprinted in* 1986 U.S.C.C.A.N. 6384. Under the proposed bill, "hospitals and physicians that conduct peer review [would] be protected from damages in suits by physicians who lose their hospital privileges, provided the peer review actions [met] the due process and other standards established in the bill." *Id.* Congress found that "the threat of private money damage liability under Federal laws, including treble damage liability under antitrust law, unreasonably discourages physicians from participating in effective professional review." 42 U.S.C. § 11101(4). Thus, Congress saw an "overriding national need to provide incentive and protection for physicians engaging in effective professional peer review." *Id.* at (5).

The House Committee on Energy and Commerce (the "Committee") reported favorably on the bill and recommended it pass. H.R. Rep. No. 99-903, at 1 (1986), *as reprinted in* 1986 U.S.C.C.A.N. 6384. To ensure that physicians would cooperate in a system of peer review intended to identify incompetent and unprofessional doctors, the Committee stated it was "essential to provide some legal immunity to doctors and hospitals that engage in peer review activities." *Id.* at 6385. "Many people in the medical field told the Subcommittee on Health and the Environment that the reporting system would inevitably result in an enormous increase in litigation because physicians facing disciplinary action will feel compelled to challenge vigorously any action taken against them. Based on recent experience, the Committee believed that many of those physicians would file antitrust lawsuits." *Id.* It noted that "doctors who are sufficiently fearful of the threat of litigation will simply not do meaningful peer review." *Id.* Thus, the Committee saw a "clear need to do something to provide protection for doctors engaging in peer review if [the National Practitioner Data Bank, a centralized system of physician reporting, also created by HCQIA] was to be workable." *Id.*

To achieve that end, the bill (which became HCQIA) provided "limited, but essential, immunity. Doctors and hospitals who have acted in accordance with the reasonable belief, due process, and other requirements of the bill are protected from damages sought by a disciplined doctor. The bill protects innocent and often helpless consumers from abuses by bad doctors without insulating improper anticompetitive behavior from redress." *Id.* at 6385-86 (emphasis added). Clearly, Congress intended a limited immunity, and envisioned that at least one type of subjective motivation would be considered in deciding immunity—evidence of "improper anticompetitive behavior."

D. Congress used clear and plain language—"reasonable belief"—in the immunity standards.

HCQIA sets four requisites that must be met to qualify for immunity, two of these require a "reasonable belief." Congress specifically chose the language of these standards to craft an immunity that would strike a balance between encouraging proper peer review and accountability for money damages in the event of improper peer review. By its clear language, the standard contemplates subjective elements. The most compelling example is malice. Malice in the peer review context in Texas is defined as "the making of a statement with knowledge that it is false, or with reckless disregard of whether it is false. Reckless disregard means that a statement is made with a high degree of awareness of probable falsity." App. 132a-133a. The Poliner jury found that each of the defendants acted maliciously, and this finding necessarily eliminates the presence of a reasonable belief. It defies logic that a "reasonable belief" can be judicially determined without consideration of all evidence regarding all the motivations in a defendant's mind, including the fact that a defendant acted with legal malice. "Belief" is "[a] conviction of the truth of a proposition existing subjectively in the mind . . . ." Black's Law Dictionary 106 (6th ed. 1991) (emphasis added).[6] Sanitizing "reasonable belief" to remove consideration of any subjective elements, especially malice, eliminates any and all meaning from the term "belief," and renders the statutory language chosen by Congress meaningless.

E. Congress rejected broad immunity to avoid shielding anticompetitive behavior and other abuse when state immunity laws were avoided.

The Committee believed "that the purposes of the bill require protection for persons engaging in professional review." H.R. Rep. No. 99-903, at 8-9 (1986), *as reprinted in* 1986 U.S.C.C.A.N. 6384, 6391. In support of this belief, the Committee stated "[u]nder current state law, most professional review activities are protected by immunity and confidentiality provisions. A small but growing number of recent federal antitrust actions, however, have been used to override those protections. Because the [National Practitioner Data Bank] will most likely increase the volume of such suits, the Committee feels that some immunity for the peer review process is necessary." *Id.* It is obvious that Congress was aware of the various state immunity statutes that existed[7] and did not want to affect or diminish state immunity statutes crafted by their respective legislatures for the protection of their physician citizens.[8] It did, however, want to provide immunity where there seemed to be a particular gap being used to circumvent those state immunity protections—the antitrust lawsuit. So Congress crafted its own immunity standard to fill that gap.

---

[6] Although the more recent edition of Black's has significantly pared down the lengthy definition for "belief" set forth in the sixth edition, it still contains the same "subjective" component by defining "belief" as a state of mind that regards the existence of something as likely or relatively certain." Black's Law Dictionary 164 (8th ed. 2004).

The Committee first considered establishing a very broad protection from suit for professional review actions. *See* H.R. Rep. No. 99-903, at 9 (1986), *as reprinted in* 1986 U.S.C.C.A.N. 6384, 6391. However, "in response to concerns that such protection might be abused and serve as a shield for anti-competitive economic actions under the guise of quality controls," the Committee restricted the protection to provide immunity only from damages in private actions, and only for proper peer review. *Id.* A clearer statement regarding Congressional intent could not have been made—federal immunity was not designed to shield peer review motivated by "anti-competitive economic actions." Even this Court has recognized qualified immunity is to be applied in the antitrust context. *Patrick v. Burget*, 486 U.S. at 105 n.8 ("Congress in fact insulated certain medical peer-review activities from antitrust liability in [HCQIA]. . . ." (emphasis added)).

---

[7] *See* note 17, *infra*.

[8] *See* §11115(a). However, this is exactly what has happened, as discussed in section H(3) below.

F. Congressional intent supports a more objective "reasonable belief" standard but in no way eliminates consideration of subjective intent.

Initially, the Committee considered a "good faith" standard. H.R. Rep. No. 99-903, at 10, (1986), *as reprinted in* 1986 U.S.C.C.A.N. 6384, 6392. However, there were concerns that "good faith" might be interpreted "as requiring only a test of the subjective state of mind of the physicians conducting the professional review action." *Id.* Thus, the Committee changed to a more objective "reasonable belief" standard, which appeared to be more restrictive than a "good faith" test.[9] *Id.* at 6392-93. "The Committee [intended] that this test be satisfied if the reviewers, with the information available to them at the time of the professional review action, would reasonably have concluded that their action would restrict incompetent behavior or would protect patients." *Id.* at 6393. Congress focused the inquiry on the state of mind of the defendant at the time of the action, which must also be reasonable.

---

[9] Thus, a defendant could not receive immunity for unreasonable behavior just because he claimed that he acted in "good faith." The belief would also have to be reasonable for immunity to be conferred.

Granted, the Committee believed that a more objective "reasonable belief" standard would be met "in the overwhelming majority of professional review actions." *Id.* Thus, a presumption to that effect was provided in the bill, "requiring a plaintiff to show by clear and convincing evidence[10] that no such reasonable belief existed at the time of the professional review action." *Id.* But the Committee's language also shows it recognized there would be at least some cases in which the "reasonable belief" standard would not be met.

Nothing in the "reasonable belief" test articulated by Congress precludes the consideration of factual evidence of a bias or improper motive in conjunction with other evidence about professional competence or patient care. Simply because Congress favored a "more objective" standard it does not follow that all subjective motives unrelated to health care are irrelevant in the analysis. After all, when HCQIA was enacted as part of Public Law 99-660, its title remained "Title IV – Encouraging Good Faith Professional Review Activities." Pub. L. No. 99-660, 100 Stat. 3743 (1986) (emphasis added). Aside from the title of the bill itself, Congress also stated its "intent that physicians receive fair and unbiased review to protect their reputations and medical practices." H.R. Rep. No. 99-903, at 11 (1986), *as reprinted* in 1986 U.S.C.C.A.N. 6384, 6393. Further, Congress specified that, "to ensure that reviews of physicians pertain only to quality of care . . . members of the hearing panel, or the hearing officer, cannot be in direct economic competition with the physician-respondent." *Id.* In the face of all this guidance, Congress would be stunned to know how HCQIA immunity has been recast.

---

[10] Although the proposed bill would have required plaintiff to provide "clear and convincing evidence" to rebut the presumption, the enacted statute adopted the less burdensome "preponderance of the evidence" test. *See* 42 U.S.C. § 11112(a).

G. Courts have transformed qualified immunity by wholly disregarding subjective intent.

Austin v. McNamara was the first case to conclude that subjective intent must be wholly eliminated from the analysis. In the *Austin* opinion, after citing much of the same language regarding the legislative history of HCQIA set forth above, the Ninth Circuit proclaimed (without any authority) that a physician's allegations of "animosity" and "hostility" are "irrelevant to the reasonableness standards of §11112(a). The test is an objective one, so bad faith is immaterial." *Austin v. McNamara*, 979 F.2d at 734. In direct contrast to the "more objective" test that Congress employed, the *Austin* court invented a highly simplistic test that turns a blind eye to bad faith, malice, or actual motive.[11]

---

[11] The dissent in *Austin* points out the serious flaw in this holding, stating that "[e]vidence of motive and intent is relevant to show whether the defendants possessed a reasonable belief that the final revocation was warranted by the facts known. Moreover, the legislative history discussing the due process requirements of section 11112 makes clear that it is essential that 'physicians receive fair and unbiased review to protect their reputation and medical practices' (internal citations omitted). Any inquiry into

One by one, circuit courts of appeal have parroted this erroneous standard, which now supplants the actual standard for immunity as articulated by Congress. The illogical result is that there exists no category of evidence that can ever rebut the presumption that a defendant had a "reasonable belief." Thus, each and every case in which the "reasonable belief" prongs of immunity have been analyzed by a circuit court of appeals has been dismissed as a matter of law based on federal immunity.[12] The Poliner case was the only exception until the Fifth Circuit reversed.

---

the reasonableness of the reviewers' beliefs should at least consider any evidence of bias or ulterior motive even though an objective standard ultimately applies." *Id.* at 741, n. 3.

[12] The Tenth Circuit is the only circuit court of appeals that has upheld a lower court's finding that the presumption of immunity under HCQIA was rebutted by plaintiff. In *Brown v. Presbyterian Healthcare Servs.*, 101 F.3d 1324 (10th Cir. 1996), the court affirmed the district court's conclusion that Dr. Brown presented sufficient evidence for a reasonable jury to find that her peer review action was not taken after a "reasonable effort to obtain the facts of the matter" and, thus, defendants were not immune, as a matter of law, from damages stemming from the revocation of Dr. Brown's privileges. The analyses of both courts was focused on the third prong and did not address the nature of the "reasonable belief" test.

H. The resulting effects of the judicial misinterpretation clearly turn HCQIA on its head.

1. Effect—There exists no evidence that can be used to rebut presumption of HCQIA immunity.

The circuit courts of appeal have spent much time telling physicians what cannot be used to rebut the presumption of immunity, but are suspiciously silent as to how a physician could actually rebut the presumption.[13] The Fifth Circuit's decision in Poliner is a good example. Despite its claim that it considered the "totality of the circumstances" (App. 22a), the court plainly disregarded any and all evidence that could have conceivably rebutted the presumed immunity. Subjective motives are not considered—the erroneous exclusion of this entire category of evidence is the reason for this petition for certiorari. Another category of excluded evidence involves the departure from the medical staff bylaws (especially a knowing violation), which would seem a logical barometer for "reasonableness." Not so. The Fifth Circuit specifically states that evidence of a knowing violation of the medical staff bylaws does not "defeat" immunity and the overall analysis makes it plain that the Fifth Circuit did not even consider bylaws violations that knowingly occurred in evaluating "reasonable belief." App. 16a-37a. Other courts are no different. They consistently disregard or severely minimize evidence of the violation of medical staff bylaws.[14] Lastly, the Fifth Circuit dismissed Poliner's numerous expert opinions (another category of evidence), and stated that defendants' beliefs could not have been unreasonable despite the medical facts of the care given and the outlandish criticisms made of Poliner. App. 23a-24a. Other courts play this same game with their various analyses, rendering it impossible to imagine any set of circumstances where "reasonable belief" will not be found as a matter of law.

---

[13] The one exception appears to be in cases where the physician plaintiff has failed to present evidence raising issues of malice and subjective motives not in the interest of patient care. For example, in *Mathews v. Lancaster Gen. Hosp.*, the Third Circuit determined that Dr. Mathews failed to rebut the first prong of HCQIA requirements because he did not present evidence that professional review action "was motivated by anything other than a reasonable belief that it would further quality health care." *Mathews v. Lancaster Gen. Hosp.*, 87 F.3d 624, 635 (3^{d}Cir. 1996).

2. Effect—Courts now routinely usurp the fact-finding role of the jury.

Congress envisioned that, for most cases, HCQIA immunity would be determined by the courts as a matter of law before a jury trial. Congress stated "this

---

[14] *See, e.g., Wieters v. Roper Hosp., Inc.*, 58 Fed.Appx. 40, 46 (4th Cir. 2003) (even if procedure strayed from letter of the bylaws, it still meets immunity requirements if it was "fair to the physician under the circumstances"); *Meyers v. Columbia / HCA Healthcare Corp.*, 341 F.3d 461, 469-70 (6th Cir. 2003) (even assuming bylaws were violated, notice and procedures complied with HCQIA's statutory "safe harbor"); *Bakare v. Pinnacle Health Hosp., Inc.*, 469 F.Supp.2d 272, 290 at n. 33 (M.D. Pa. 2006) ("court need not determine whether MEC followed the Bylaws"); *Wahi v. Charleston Area Med. Ctr.*, 453 F.Supp.2d 942, (S.D.W.Va. 2006) (failure to follow bylaws procedures did not render process inadequate under HCQIA).

[reasonable belief] standard will be met in the overwhelming majority of professional review actions." H.R. Rep. No. 99-903, at 10 (1986), *as reprinted in* 1986 U.S.C.C.A.N. 6384, 6393. For this "overwhelming majority," Congress specified a procedure for early judicial determination of immunity. Congress intended that HCQIA provisions "allow defendants to file motions to resolve the issue of immunity in as expeditious a manner as possible." *See id.* at 6394. "The provisions would allow a court to make a determination that the defendant has or has not met the standards specified in [42 U.S.C. § 11112(a)]. The Committee intend[ed] that the court could so rule even though other issues in the case remain to be resolved. For example, a court might determine at an early stage of the litigation that the defendant has met the standards, even though the plaintiff might be able to demonstrate that the professional review action was otherwise improper. At that point, it would be in order for the court to rule on immunity." *Id.*

But the Committee observed that "[i]f the professional review actions being challenged fail to meet the standards of [§ 11112(a)], no immunity is provided and the suit can be tried without regard to the provisions of this bill." *Id.* at 6391. This crucial sentence supports the obvious conclusion that Congress envisioned cases in which immunity would not be decided as a matter of law. In these cases, the discrete fact issues underlying the four HCQIA standards would be determined by a jury.

Thus, at summary judgment, a court using a "somewhat unusual standard" given the rebuttable presumption determines: "Might a reasonable jury, viewing the facts in the best light for [plaintiff], conclude that he has shown, by a preponderance of the evidence, that the defendants' actions are outside the scope of § 11112(a)?" *Austin*, 979 F.2d at 734*; see also Imperial v. Suburban Hosp. Ass'n, Inc.*, 37 F.3d 1026, 1030 (4th Cir.1994).

The Poliner trial court, at the summary judgment stage, could not have implemented this complex legal standard any more carefully or thoughtfully. App. 96a. The court stated:

> Dr. Poliner contends that he has raised material issues of fact as to whether Defendants were motivated by something other than a reasonable belief that their actions would further the care of the Hospital's patients. More specifically, Plaintiff alleges that the combination of the personal animosity toward him and the desire to eliminate an economic competitor resulted in a conspiracy to eliminate plaintiff from practicing at [the Hospital]. In making this examination, most courts have adopted an objective standard of reasonableness [citations omitted]. That is, the focus of this inquiry is not whether the defendants' initial concerns are ultimately proven to be medically sound. Rather, the objective inquiry focuses on whether the professional action taken against [Poliner] was taken "in the reasonable belief that the actions was in the furtherance of quality health care [citations omitted]."

App. 97a (emphasis added). Notably, the Poliner trial court did not disregard the evidence of personal animosity and anticompetitive motives as the Fifth Circuit later would; nowhere in the summary judgment opinion is any statement of law that this category of evidence is "irrelevant." Instead, as Congress intended, this category of evidence factored into the trial court's determination (using an "objective inquiry") that fact issues regarding "reasonable belief" were raised and needed to be determined by a jury. In stark contrast to the Fifth Circuit and its sister circuit courts, the Poliner trial court, in its summary judgment ruling, got it right.[15]

The Eleventh Circuit confirms that the Poliner trial court employed the correct procedure at summary judgment and in its subsequent instructions to the jury at trial. "If there are disputed subsidiary issues of fact concerning HCQIA immunity, such as whether the disciplined physician was given adequate notice of the charges and opportunity to be heard, the court may ask the jury to resolve subsidiary factual questions by responding to special interrogatories." *Bryan v. James E. Holmes Reg'l Med Ctr.*, 33 F.3d 1318, 1333 (11th Cir.1994). This observation would seemingly also apply to the fact question of whether defendants had a "reasonable belief."[16]

---

[15] At least one other federal district court appears to have also gotten it right. *See Islami v. Covenant Med. Ctr.*, 822 F.Supp. 1361 (N.D. Iowa 1992) (stating a jury can and should decide any discrete, disputed material fact issues essential to the final determination of immunity as a matter of law if that determination cannot be made at the summary judgment stage and finding that plaintiff raised a fact issue regarding the fairness and adequacy of the process in his peer review).

In Poliner, the trial court gave the jury discrete factual questions to resolve and the jury answered the discrete factual questions as to each defendant, separately distinguishing the May 14 action from the May 29 action. App. 126a-132a. The jury found that, for each defendant, the "reasonable belief" standards in the first and fourth prongs were not met. The jury answered each of these factual questions in a way that allowed the trial court ultimately to determine that immunity could not be conferred on defendants as a matter of law. The Poliner case showed there was an actual route to achieving accountability for damage done to a career and reputation under the guise of medical peer review—the way Congress intended HCQIA to work. However, the Fifth Circuit's reversal drastically changes this. The complex process for determining qualified immunity under HCQIA (which, in at least some cases, requires jury fact finding) can now never operate as Congress intended. The Poliner case has turned from an example of the proper operation of immunity to proof of its utter failure.

3. Effect—Individual state laws are now rendered meaningless.

In addition to granting immunity, HCQIA expressly allows individual states to provide additional or greater protection to peer review activities. "Except as specifically provided in this subchapter, nothing in this subchapter shall be construed as changing the liabilities or immunities under law or as preempting or overriding any State law which provides incentives, immunities, or protection for those engaged in a professional review action that is in addition to or greater than that provided by this subchapter." 42 U.S.C. § 11115(a). This Court has explicitly stated that "[t]he Act expressly provides that it does not change other 'immunities under law,' § 11115(a), including the state-action immunity, thus allowing States to immunize peer-review action that does not meet the federal standard." *Patrick v. Burget*, 486 U.S. at 105 n.8. Nothing in the legislative history indicates that Congress intended for HCQIA to completely preempt state law in this area. *See Zamaniam v. Christian Health Ministry*, No. 94-1781, 1994 WL 396179 at *2 (E.D. La. 1994) (not reported) (addressing plaintiff's jurisdictional argument based on complete preemption doctrine and finding no statutory evidence of congressional intent to preempt state peer review laws).

---

[16] Determinations of "reasonableness" and "adequacy" are inherently fact-based inquiries. *See, e.g., Islami v. Covenant Med. Ctr.*, 822 F.Supp. 1361, 1377 (N.D. Iowa 1992).

State peer review laws generally provide immunity except in situations of malice, fraud, or willful and wanton conduct.[17] For example, soon after HCQIA was enacted in 1986, Texas (applicable in Poliner) enacted its own law to provide that peer review actions taken "without malice" are immune from liability.[18] From

---

[17] Thirty states currently have medical peer review immunity standards that are related to whether the defendants "acted without malice." *See* Ala. Code § 6-5-333 (2006); Ark. Code Ann. § 20-9-502 (2005); Cal. Health & Safety Code § 1370 (West 2003); Cal. Civ. Code § 43.7 (West 2003); Conn. Gen. Stat. Ann. § 19a-17b (West 2003); Del. Code Ann. tit. 24 § 1768 (2003); Ga. Code Ann. §§ 31-7-132, 31-7-141 (2001); Haw. Rev. Stat. § 663-

---

1.7 (2002); Iowa Code Ann. § 147.135 (West 2003); Kan. Stat. Ann. § 65-442 (2002); La. Rev. Stat. Ann. § 13:3715.3 (West 2002); Mich. Comp. Laws Ann. § 331.531 (West 2003); Miss. Code Ann. § 41-63-5 (2003); Mo. Ann. Stat. § 537.035 (West 2003); Mont. Code Ann. § 37-2-201 (2002); Neb. Rev. Stat. § 71-147.01 (2003); N.J. Stat. Ann § 2A:84A-22.10 (West 2003); N.Y. Educ. Law § 6527 (McKinney 2003); N.C. Gen. Stat. § 131E-95 (2003); N.D. Cent. Code § 23-34-06 (2003); Ohio Rev. Code Ann. §§ 2305.25, 2305.28 (West 2003); Pa. Stat. Ann. tit. 63, § 425.3 (West 2003); R.I. Gen. Laws §§ 5-37.3-7, 23-17-25 (2002); S.C. Code Ann. § 40-71-10 (Law Co-op. 2003); S.D. Codified Laws § 36-4-25 (2003); Tenn. Code Ann. § 63-6-219 (2003); Tex. Occ. Code Ann. § 160.010 (Vernon 2003); Utah Code Ann. §§ 58-13-4, 58-13-5 (2003); Vt. Stat. Ann. tit. 26, § 1442 (2002); Va. Code Ann. § 8.01-581.13 (Michie 2003); Wyo. Stat. Ann. §§ 35-17-103, 33-26-408 (Michie 2002). Twelve states have standards related to whether the defendants "acted in good faith." *See* Del. Code Ann. tit. 24 § 1768 (2003); Ind. Code Ann. §§ 34-30-15-15, 34-30-15-17 (West 2003); Kan. Stat. Ann. § 65-442 (2002); Mass. Gen. Laws Ann. ch. 111, § 203 (2003); Mo. Ann. Stat. § 537.035 (West 2003); N.H. Rev. Stat. Ann. §§ 329:17, 507:8-c (2002); Okla. Stat. Ann. tit. 63, §§ 1-1709, 1-1709.1 (West 2002); Or. Rev. Stat. § 41.675 (2002); Tenn. Code Ann. § 63-6-219 (2003); Utah Code Ann. §§ 58-13-4, 58-13-5 (2003); Va. Code Ann. § 8.01-581.13 (Michie 2003);Wis. Stat. Ann. § 146.37 (West 2003). Three states have standards related to whether the defendants "acted without fraud." *See* Ark. Code Ann. § 20-9-502 (Michie 2003); Fla. Stat. Ann. § 766.101 (West 2003); N.C. Gen. Stat. § 131E-95 (2003). And one state has standards related to whether the defendants acted "without willful and wanton misconduct." *See* 210 Ill. Comp. Stat. Ann. 85/10.2 (West 2003); 225 Ill. Comp. Stat. Ann. 60/5 (West 2003).

[18] Texas peer review immunity, enacted in 1987, provided immunity from civil liability for "a person, health-care entity, or medical peer review committee, that, without malice, participates

the language of the Texas statute and the case law interpreting it, it is clear Texas took the additional step of providing more protection to medical peer review than HCQIA. *Roe v. Walls Reg'l Hosp., Inc.*, 21 S.W.3d 647, 653 (Tex. App.—Waco 2000, no pet.) (citing *St Luke's Episcopal Hosp. v. Agbor*, 952 S.W.2d 503, 507 (Tex. 1997)). Qualified immunity under Texas state law can only be defeated by a showing that the defendant acted with actual malice. *Id.* If a plaintiff shows malice, the Texas legislature has made its intent known—it will protect its physician citizens from these peer review actions and allow those citizens to hold the responsible parties accountable through the remedy of civil damages.[19]

---

in medical peer review actively or furnishes records, information, or assistance to a medical peer review committee or the board." *See* Tex.Rev.Civ. Stat. Ann. art. 4495b section 5.06(m) (repealed) (emphasis added). Texas's current immunity statute continues this "without malice" standard. TEX. OCC. CODE ANN. § 160.010(a)(1)-(3) (Vernon 2001) (emphasis added).

[19] The Fifth Circuit minimizes the remedy of civil damages in this context by stating "[t]he doors to the courts remain open to doctors who are subjected to unjustified or malicious peer review, and they may seek appropriate injunctive and declaratory relief in response to such treatment." App. 28a. But the availability of such relief is no substitute for money damages otherwise available under federal or state law, particularly if there are financial consequences (such as lost earnings and damage to professional reputation). As this Court said in a case requiring backpay for a civil rights violation under Title VII: "If employers faced only the prospect of an injunctive order, they would have little incentive to shun practices of dubious legality. It is the reasonably certain prospect of a backpay award that "provide(s) the spur or catalyst which causes employers and unions to self-examine and to self-evaluate their employment practices and to endeavor to eliminate, so far as possible, the last vestiges of an unfortunate and

HCQIA immunity, as currently interpreted by the courts, completely overrides any state law that mandates accountability for peer review conducted with bad faith, malice, or intentional fraud. The ability to rebut the presumption of immunity under state law will always be stymied by the current "objective reasonableness" test under HCQIA. Thus, a peer review action can be taken maliciously and in bad faith as long as there is any kind of quality of care issue or professional competence issue that can be raised.[20] In essence, state laws enacted to protect physician citizens from malicious peer review are now meaningless. Although Congress stated an intent not to override state law, that is precisely what has occurred.

4. Effect—Absolute immunity has resulted.

The circuit courts of appeal refuse to consider bad motive—period. They do not even attempt to analyze the "totality of the circumstances," which necessarily includes the consideration of subjective motives along with possible legitimate motives. Instead, the circuit courts of appeal seize on any conceivable proper motive

---

ignominious page in this country's history." *Albemarle Paper Co. v. Moody*, 422 U.S. 405, 417-18 (1975).

[20] Perhaps one of the most ridiculous statements illustrating this absurd result comes from an Ohio state court of appeals in *Cowett v. TCH Pediatrics, Inc.*—"[i]f a hospital rids itself of a doctor both because of health care concerns and because of financial/political concerns, HCQIA will give the hospital immunity from suit." *Cowett v. TCH Pediatrics, Inc.*, 7th Dist. No. 05 MA 138, 2006 Ohio-5269, at ¶23 (Ohio App. 2006) (emphasis in the original).

(true or not) as justification. The limited immunity envisioned by Congress is thus rendered an impossibility. Now that the courts have wholly and categorically disregarded such evidence, peer review is absolutely immune. Absolute immunity in the peer review context (where independent hospitals and health care entities and their participants receive absolute protection) is a grave error.[21] Even worse, as it now stands, this absolute immunity exists under the guise of "qualified immunity," creating a false sense of security for physicians who must operate in this precarious and unforgiving environment.

---

[21] This is especially true considering that these diffuse, separate entities conduct peer review independent from any state or federal governmental authority. There exist none of the hallmarks under which absolute immunity from civil liability has historically been applied. There are five contexts in which this Court has approved the application of absolute immunity from civil liability: (1) prosecutors performing prosecutorial acts (*see Imbler v. Pachtman*, 424 U.S. 409, 430-31 (1976)); (2) judges performing judicial tasks (*see Stump v. Sparkman*, 435 U.S. 349, 355 (1978)) and state officials or employees performing adjudicatory tasks (*see Olsen v. Idaho State Bd. of Med.*, 363 F.3d 916 (9th Cir. 2004)); (3) legislators performing legislative tasks (*see Bogan v. Scott-Harris*, 523 U.S. 44 (1998)); (4) police officers who testify as witnesses (*see Briscoe v. LaHue*, 460 U.S. 325 (1983)); and (5) the President of the United States for acts taken while in office (*see Nixon v. Fitzgerald*, 457 U.S. 731 (1982); *see also Clinton v. Jones*, 520 U.S. 681, 696 (1997)). In each of these contexts, unlike in medical peer review, the actors are government officials (most often elected) and not private individuals acting on behalf of a private organization. Additionally, the immunity is granted due to concerns that civil suits would be disruptive to the flow of government. *See, e.g.*, *Spalding v. Vilas*, 161 U.S. 483, 498 (1896); *see also Pierson v. Ray*, 386 U.S. 547, 564 n. 4 (1967). Further, in these recognized instances absolute immunity is expressly limited by the Court to conduct undertaken in the exercise of certain, specific acts within the function of the actor's office. *See, e.g.*, *Butz v. Economou*, 438 U.S. 478, 508-17 (1978); *Imbler v. Pachtman*, 424 U.S. 409, 430-31 (1976); *Spalding v. Vilas*, 161 U.S. 483, 498 (1896). Finally, these persons to whom the Court has extended absolute immunity plainly function in a governmental role such

I. The stakes are high and the consequences serious—for physicians and patients.

The current state of immunity for peer review is made more tragic by the high stakes involved. There are a myriad of interwoven reporting requirements under federal and state law that may be triggered when an adverse action is taken. State licensing boards that monitor any such events have the power to revoke a physician's license to practice medicine. An adverse action at just one hospital can result in a "domino effect" whereby other hospitals, health care entities, insurance companies and other third parties take action against a physician because of the original adverse action, or at least conduct their own investigations, thus putting a physician in peril of losing privileges elsewhere, and jeopardizing his ability to practice medicine anywhere.

---

that they are presumed to be aware of applicable laws and reasonably conscious of the clearly established constitutional and statutory rights of individuals who are subject to their conduct. None of these hallmarks exist in a medical peer review conducted by individual physicians who may or may not understand, and are certainly not bound by, due process laws or evidentiary rules. Further, peer review proceedings (unlike judicial and prosecutorial proceedings) are ostensibly governed by medical staff bylaws, which are not subject to any uniformity or standard, can be vastly different from hospital to hospital, and may or may not co-exist with applicable law or even constitute an enforceable contract.

An equally tragic victim is the one in whose name peer review and its various immunities were originally created—the patient. If peer review is carried out because of malicious intent (anticompetitive, political, personal, or otherwise) and is protected nonetheless by HCQIA immunity, the goals of protecting patients and ensuring patient care (which should be the pre-eminent considerations in peer review) take on a subordinate position. Physicians subject to review are not judged on the basis of their medical competency, and privileges may be removed (with devastating and possibly career-ending ramifications) in spite of competency. Good doctors are denied the ability to practice medicine, and patient care suffers.

J. Compelling reasons exist for the Court to stop the derailment of HCQIA.

HCQIA has been derailed. If the Fifth Circuit had departed from its sister circuits on an important federal issue such as this, or if the circuits were evenly divided, the Court would likely step in and review the case. The fact that the serious departure came when the Ninth Circuit first weighed in on the interpretation of "reasonable belief" standard and got it wrong (and other courts either blindly followed or had no choice) does not decrease in any way the need for this Court to address this issue and correct this serious misinterpretation of the law. This conflict is crucial enough to physicians, patients, and the health care system as a whole to warrant certiorari. The Court is the last hope to get the statute back on track and allow immunity in medical peer review to operate as Congress intended.

Without the grant of certiorari by this Court, the courts will continue down the current path of judicial misinterpretation, providing, in effect, absolute immunity for medical peer review. As is the case now, there will never be circumstances under which the "reasonable belief" tests under HCQIA are not met as a matter of law, even where juries find clear evidence of malice and motives unrelated to health care and conclude that no reasonable belief exists—as was the case in Poliner.

CONCLUSION

The petition for certiorari should be granted.

Respectfully submitted,

KANE RUSSELL COLEMAN & LOGAN PC

By: Michael A. Logan
Karin M. Zaner*
3700 Thanksgiving Tower
1601 Elm Street
Dallas, Texas 75201
Telephone: 214.777.4200
Facsimile: 214.777.4299

**Counsel of Record*
Counsel for Petitioners

Dated: October 21, 2008

APPENDIX

APPENDIX A

IN THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

No. 06-11235

[Filed July 23, 2008]

LAWRENCE R POLINER, MD;
LAWRENCE R POLINER, MD, PA

Plaintiffs-Appellees

v.

TEXAS HEALTH SYSTEMS, a Texas Non-Profit Corporation, doing business as Presbyterian Hospital of Dallas;
JAMES KNOCHEL, MD

Defendants-Appellants

Appeals from the United States District Court for the Northern District of Texas

Before KING, HIGGINBOTHAM, and SOUTHWICK, Circuit Judges.

PATRICK E. HIGGINBOTHAM, Circuit Judge:

This appeal brings to us a judgment awarding some $33 million, including prejudgment interest, against a major hospital and leading physician for alleged defamations. As we will explain, this extraordinary judgment rests on limited restrictions of Dr. Lawrence Poliner's privileges at Presbyterian Hospital over a period of fewer than twenty-nine days to investigate concerns involving his handling of several patients. This peer review, which was headed by Dr. James Knochel, led to a suspension of Poliner's cardiac catheterization lab and echocardiography privileges that lasted approximately five months. Poliner sued Knochel, Presbyterian, and other doctors involved in the peer review alleging various federal and state law violations. The district court found that the suspension enjoyed immunity from money damages under the federal Health Care Quality Improvement Act (HCQIA),[1] and granted a partial summary judgment. But the court concluded that whether the temporary restrictions of privileges during the investigation enjoyed immunity from money damages presented questions for a jury.

The case proceeded to trial solely on the temporary restrictions of privileges. The jury found for Poliner on his defamation claims.[2] Poliner was able to offer evidence at trial of actual loss of income of about $10,000-but was awarded more than $90 million in defamation damages, nearly all for mental anguish and injury to career. The jury also awarded $110 million in punitive damages. The district court ordered a remittitur of the damages and entered judgment against Defendants. We hold that Defendants are immune under the HCQIA from money damages for the temporary restrictions of Poliner's privileges. We reverse and render judgment for Defendants.

---

[1] *See* 42 U.S.C. § 11101 *et seq.*

[2] The jury also found for Poliner on his breach of contract business disparagement, interference with contractual relations and intentional infliction of emotional distress claims. Poliner elected to recover under the defamation theory after trial.

I. Facts and Proceedings Below

A.

On May 12, 1998, Patient 36 presented in Presbyterian's emergency room with chest pains, and he was referred to Dr. Lawrence Poliner, an interventional cardiologist who had a solo practice at Presbyterian Hospital. Diagnostic tests indicated that the patient was suffering from a heart attack, and that the patient's right coronary artery (RCA) was partially blocked. Poliner performed a procedure to open the artery. However, Poliner made a diagnostic mistake: the patient's left anterior descending artery (LAD) was completely blocked, and Poliner missed it. Another doctor, Dr. Tony Das, saw the LAD on a monitor in the control room. Poliner learned that he missed the LAD sometime after completing the procedure. Das spoke to him about the procedure and the LAD. Dr. Charles Levin, the director of the catheterization lab, heard that day that Poliner had performed an emergency procedure. He reviewed the patient's films, and then spoke with Poliner.

In an addendum to the chart, Poliner admitted that he missed the totally blocked LAD. He wrote that "[i]n reviewing the films, it is apparent that the left anterior descending coronary artery is totally occluded," and that "[a]t the time that this study was done and visualizing the anatomy in the laboratory from the video, this was not apparent, but it is obvious from reviewing the films." Poliner indicated that he might have treated the LAD before the RCA had he seen it.

Patient 36 also suffered post-procedure complications. The patient suffered internal bleeding and eventually went into shock, deteriorating to the point that a critical care specialist, Dr. Kenney Weinmeister, was brought in. Weinmeister testified that the patient was suffering from "severe metabolic acidosis," which "was due to what we call hypovolemia or essentially blood loss so that he didn't have enough fluid in his vessels to maintain blood pressure, and that was due to a retroperitoneal hemorrhage or bleeding." The patient was, in his words, "near respiratory failure." Weinmeister testified that, had he not intervened, the patient could have died within an hour. Poliner was in the ICU a number of times following the patient's procedure. There were problems contacting Poliner, although at trial there was testimony that he tried to call the ICU several times but he could not get through. Poliner also sent his wife, who is a nurse, over to check on the patient. As the patient's condition deteriorated in the afternoon, Poliner was not present. There was evidence at trial that he had another procedure scheduled that afternoon, but the time line is not entirely clear. Dr. John Harper, the chief of cardiology, was told about Patient 36 on May 12, and he reviewed the patient's chart and films.

Dr. James Knochel, the chairman of the Internal Medicine Department (IMD), learned about Patient 36 from Das and Weinmeister the next day, May 13.[3] This, however, was not the first of Poliner's patients to come to Knochel's attention. Cardiology was part of the IMD, and four of Poliner's other patients-Patients 3, 9, 10, and 18-had been referred by the hospital's Clinical Risk Review Committee (CRRC) to Knochel and the Internal Medicine Advisory Committee (IMAC), which Knochel chaired, for review.[4]

---

[3] The trial testimony is somewhat unclear about what exactly Knochel knew on May 13 about the post-procedure care Patient 36 received. Knochel and Weinmeister testified that they spoke about the patient. Weinmeister testified that he told Knochel about his concerns regarding Patient 36's post-procedure problems, while Knochel suggested in his testimony that he may not have been aware of all of the post-procedure problems.

[4] Generally, when an incident occurred at Presbyterian, including something relating to patient care, a Committee Event Report Form (CERF) would be completed. The CERF was sent to the hospital's risk management department for processing. If the event involved clinical issues, the CERF was forwarded to the CRRC. The CRRC would review the incident, and if the committee had concerns, it would forward the case to the relevant department for further review. When an incident involved the IMD, Knochel would receive the referral from CRRC, and the IMAC would assist in determining whether the patient had received acceptable care.

Poliner's care of Patients 3,[5] 9,[6] 10,[7] and 18[8] involved different issues of varying degrees of concern, but in each case, his medical judgment had been questioned and, to some extent, criticized.[9] Although Patient 10 had been reviewed and cleared by the IMAC in March 1997, the other cases were of recent vintage. The CRRC referred Patients 3 and 18 to the IMD in early 1998. Knochel asked a cardiologist to review each case, and the IMAC considered the cases at the end of April. The CRRC referred Patient 9 to the IMD in April. Levin completed a review of the case sometime before May 13, although the IMAC had yet to take up the case. It was against this backdrop that Knochel learned of Patient 36. Knochel consulted with Harper, Levin, various hospital administrators and the members of the IMC on May 13, and decided that he would seek an abeyance—a temporary restriction—of Poliner's cath lab privileges to allow for an investigation as provided for in the Medical Staff bylaws.[10]

---

[5] In December 1997, Poliner treated Patient 3. The issue here was Poliner's decision to re-use a sheath site for a second procedure after the nurses expressed concern that the site may have been contaminated by urine and blood. Poliner wanted to preserve the other sheath site in case another procedure was required.

[6] Poliner treated Patient 9 in October 1997. The procedure performed by Poliner was not questioned, but other treatment decisions were. There were concerns about the amount of blood thinner ordered pre-procedure, as well as orders for additional blood thinner and another drug post-procedure. At approximately 2:00 a.m., the patient was experiencing stroke-like symptoms. A nurse called Poliner, and he ordered a platelet infusion. Poliner did not then return to Presbyterian to evaluate the patient, although there may have been little else he could have done at the time. Nor did he order a CT scan or request a neurological consult. Poliner returned to the hospital in the morning and requested the neurological consult. The patient subsequently had CT scans and underwent surgery later in the day. The case involved several nursing errors as well.

[7] Poliner performed a catheterization on Patient 10 in the fall of 1996. The patient had shellfish and Betadine allergies. There were concerns at the time that a shellfish allergy was predictive of an allergy to iodine-containing contrast dye that was used in catheterizations. The patient refused to be pretreated with Benadryl. Poliner decided to proceed with the procedure. The patient developed a rash, although it is unclear whether the contrast-dye in fact caused the rash. The primary concern was Poliner's decision to proceed with the procedure without any allergy pretreatment.

[8] Patient 18, an 88-year-old woman, presented in the emergency room with a heart attack in September 1997. She was referred to Poliner, and he decided to perform a catheterization. The patient died during the procedure. The primary issue was whether it was appropriate to attempt the procedure or whether she should have been treated medically.

---

[9] One other case discussed at trial involved a mistake Poliner made during a catheterization. Poliner accidentally threaded a catheter through Patient 39's vein instead of the artery. The primary concern was not that Poliner initially entered the vein by accident, but that it took him too long to realize the mistake; indeed, the catheter reached the patient's heart. The parties dispute whether this case factored into Knochel's decision, but for our purposes, it does not matter whether it, did or not.

[10] Presbyterian's Medical Staff bylaws provide that

> [w]henever the activities or professional conduct of any physician are of such concern that in the assessment of the department chairman, vice-chairman, or advisory committee, further evaluation of the activities or professional conduct is necessary, the department chairman, vice-chairman, or advisory committee may hold certain clinical privileges of the physician in abeyance for

Late on May 13, Knochel met with Poliner, Harper, and Levin, and asked Poliner to agree to the abeyance. When Poliner asked what his options were, Knochel told him that the alternative was suspension of his privileges.[11] The abeyance letter was delivered to Poliner the next afternoon, May 14, and Knochel asked Poliner to sign and return it by 5:00 p.m. The letter advised Poliner that Patient 36 was the catalyst, and that Patients 3, 9, and 18 had also been referred by the CRRC to the IMD. The letter explained that Knochel was going to appoint an ad hoc committee of cardiologists to conduct a review, and that Poliner would have the opportunity to meet with Knochel and the IMAC to respond to any concerns raised by the committee that could lead to corrective action prior to the action being taken. Poliner requested more time so he could consult a lawyer, but Knochel declined. Poliner signed the abeyance request. Poliner subsequently engaged legal counsel.

Knochel immediately appointed an ad hoc committee of six cardiologists to review a sample of Poliner's cases. The committee reviewed 44 cases, and

---

a period of up to fifteen (15) days (the initial action) while additional review is performed. Such action shall be known as Abeyance. The physician must agree to the abeyance prior to the taking of such action. If the physician does not agree to the abeyance, the department will proceed with the corrective action or suspension.

[11] The bylaws allow for a summary suspension of clinical privileges "when the acts of a practitioner through his lack of competence, impaired status, behavior or failure to care adequately for his patients constitutes a present danger to the health of his patients."

concluded that Poliner gave substandard care in more than half. The IMAC met on May 27, the thirteenth day of the abeyance, to consider the ad hoc committee report, and recommended conducting additional reviews of echocardiograms and obtaining an outside review. The IMAC also recommended extending the abeyance of Poliner's cath lab privileges as provided for in the bylaws.[12] Knochel had a letter hand delivered to Poliner requesting his consent to the extension. The letter advised Poliner that the extension was investigational in nature and that the ad hoc committee had reviewed 44 of his cases. The letter also stated that Poliner would have an opportunity to meet with the IMAC to respond to the ad hoc committee review. Knochel again told Poliner that the alternative to abeyance was a suspension. Poliner signed the extension request on May 29.

A meeting of the IMAC was scheduled for June 11. On June 8, Knochel sent Poliner a letter advising him of the June 11 meeting and asking him to attend the meeting. Knochel provided Poliner with a list of the patients that had been reviewed and the comments of the reviewers, and told him that the patient records would be available to him. Poliner requested that the June 11 meeting be delayed to allow him more time to review the patients' files, but his request was denied and the meeting was held as scheduled. The day after the meeting, June 12, the IMAC agreed unanimously that Poliner's cath lab and echocardiography privileges should be suspended.[13]

---

[12] The bylaws provide, "The department chairman, vice-chairman or advisory committee may extend the abeyance for an additional fourteen (14) days."

An addendum to the IMAC meeting minutes reflects the following concerns about Poliner: (1) poor clinical judgment; (2) inadequate skills, including angiocardiography and echocardiography; (3) unsatisfactory documentation of medical records; and (4) substandard patient care. Knochel accepted the recommendation of the IMAC and suspended Poliner's cath lab and echocardiography privileges on June 12.

On July 10, Poliner requested a hearing on the June 12 suspension. Although he had a right to an expedited hearing under the bylaws, and the letter informing Poliner of his suspension advised him so, Poliner did not request an expedited hearing.[14] The hospital notified Poliner on August 14 that a hearing had been set for September 14, and identified who would be on the Hearing Committee. On August 19, Poliner requested a continuance. On October 5, the hospital notified Poliner that the hearing had been rescheduled for the first week of November, as Poliner had apparently requested.

---

[13] As will be seen, the district court later granted summary judgment to all defendants participating in this suspension of privileges after finding immunity under federal law. It was from this unchallenged grant of summary judgment that Poliner tacked to the argument that the temporary restriction of privileges during the investigation was distinct from the June 12 suspension.

[14] It is unclear from the bylaws whether the suspended physician must specifically request the expedited hearing or is entitled to it as of right. The bylaws state that, "a hearing for a practitioner who is under suspension which is then in effect shall be held as soon as arrangements may reasonably be made, but not later than ten (10) days from the date of receipt of such petitioner's request for hearing." The bylaws then provide, "A physician under suspension who requests an expedited hearing shall have waived his right to the 30-day hearing notice requirement." This uncertainty is of no moment.

The hearing was held as re-scheduled, and on November 9, the Hearing Committee issued its recommendations. The Committee concluded that the June 12 suspension should be upheld based on the evidence that was available at the time of the suspension but that Poliner's privileges should be reinstated with a condition.[15] Presbyterian's Medical Board accepted the Committee's recommendations. Poliner appealed the Medical Board's decision to uphold the June 12 suspension to Presbyterian's

---

[15] Specifically, the Hearing Committee recommended that "Poliner should be required to have a mandatory consultation with another cardiologist on staff who has interventional cardiology privileges in the Cardiac Cath Lab. Consultation should be for concurrence with documented indications for the selected procedure to be performed prior to the procedure." The pre-procedure consultation was to apply to the first 30 patients "for which intervention is contemplated," at which point Harper was to review those 30 cases and "make a recommendation to Dr. Knochel about Dr. Poliner's clinical performance before unrestricted privileges are to be granted." Approximately a month after the Medical Board approved this condition, it changed the condition from pre-procedure consultation to post-procedure review of the first 30 cases. This review was to be conducted by an outside reviewer, who would also review at least 30 other comparable cases from other cardiologists, ostensibly for the purpose of comparison. The outside reviewer's conclusions would be given to the cardiology chief who would then make a recommendation to Knochel for further action.

Committee on Professional Affairs (CPA). The appeal was limited to determining whether Poliner had substantially received the procedural due process provided for in the bylaws. The CPA determined he had, and Presbyterian's Board of Trustees upheld that decision.

B.

In May 2000, Poliner and his professional association sued Knochel, Harper, Levin, Presbyterian, and other doctors who had been involved in the peer review process. Poliner brought federal antitrust claims as well as state antitrust, Deceptive Trade Practices Act, and numerous tort claims. Defendants moved for summary judgment on, among other grounds, immunity under the HCQIA. On September 30, 2003, the district court issued its decision.

In analyzing HCQIA immunity, the district court concluded that there were two peer review actions, the May 14 abeyance and June 12 suspension. The court held, as to the May 14 abeyance, that fact questions precluded summary judgment. The court found a fact issue as to whether Knochel's threat to summarily suspend Poliner if he did not agree to the abeyance vitiated Poliner's consent. If Poliner had not freely agreed, the court reasoned that the abeyance was then in fact a summary suspension. If this was so, the court concluded that there were fact issues as to whether Defendants satisfied the HCQIA's standards. Thus, the court denied HCQIA immunity, as well as state law immunity, to Knochel, Harper, Levin, and Presbyterian.

The court ruled that the remaining defendants, who had served on the ad hoc committee and on the IMAC, were entitled to HCQIA and state law immunity. The court dismissed some of Poliner's claims but ruled that fact issues remained as to Poliner's remaining tort claims, including defamation, against Knochel, Harper, Levin, and Presbyterian.

The district court's summary judgment decision reshaped the case. As Poliner explained in his motion for leave to file a fourth amended complaint,

> The Court found that there was an issue of fact with respect to whether the May 14, 1998 Abeyance (the "Forced Abeyance") was in fact a de facto summary suspension. The Summary Judgment Ruling centers on the action of the Defendants in imposing the Forced Abeyance, shifting the majority of the focus of the case to the time period before and on May 14, 1998, when the Forced Abeyance was imposed. . . . Given the Summary Judgment Ruling and the Court's recent comments, it is clear that the focus of the case has shifted from an emphasis on the [June 12] Summary Suspension to an emphasis on the Forced Abeyance, a shift that the parties could not have reasonably foreseen. Now that such shift has occurred, Plaintiffs request leave to amend their Complaint for the purpose of conforming the complaint to the issues that the Court has indicated will be submitted to the jury.

Indeed, one of the amendments Poliner offered as an example in his motion was "add[ing] allegations regarding the Forced Abeyance that will allow the jury to decide whether or not the Forced Abeyance, in reality, was a summary suspension."

In a subsequent order, dated July 7, 2004, the district court clarified that Poliner could not recover any damages from the June 12 suspension: "Based on the Court's finding that all of the participants in the June 12, 1998 suspension were entitled to immunity, the Court finds that Plaintiffs are not entitled to recover damages flowing from that suspension." The order also stated that, " [i]n light of this ruling, the propriety of the [ad hoc committee's] review and the IMAC's recommendation is no longer at issue. Accordingly, evidence of malice or the motive of any of the participants in the June 12, 1998 suspension is not relevant, nor is any evidence regarding the [ad hoc committee's] analysis of the patients' files examined."

C.

After four years of litigation, Poliner's trial theory tracked this new course: he was forced to agree to the abeyances, the consequence of which was that Knochel had summarily suspended him. This mattered, he said, because, under the Medical Staff bylaws, a summary suspension was allowed when a doctor posed a "present danger to the health of his patients," and he posed no such danger. Rather, Poliner suggested that he was suspended because his solo practice was a competitive threat to the dominant cardiology groups at Presbyterian, that Knochel "had it in for" him.

The trial evidence largely focused on the propriety of Poliner's treatment of Patients 3, 9, 10, 18, 39, and especially 36, and whether the mistakes Poliner had made rendered him a "present danger." Consistent with the court's July 7 order, the jury was not told about the ad hoc committee's conclusions and the IMAC's responses, although the jury was told that there was an investigation, that Poliner was summarily suspended on July 12, and that after the November hearing, his privileges were reinstated.

During the charge conference, the district court raised the issue of whether the abeyance period involved one or two peer review actions, and eventually decided to charge the jury that the May 14 abeyance and the extension of the abeyance were separate peer review actions.

The case was submitted to the jury, which found for Poliner on all of his remaining claims. The jury awarded in aggregate more than $360 million in damages, $90 million of which were for the defamation claims. Almost all of the damages awarded were for mental anguish, injury to career, and punitive damages. Harper and Levin settled with Poliner after trial. Poliner elected to recover under his defamation theory against Knochel and Presbyterian. The district court remitted the defamation damages to $10.5 million for injury to career, $10.5 million for mental anguish, and $1.5 million in punitive damages, and further ordered prejudgment interest, which totals over $11 million. Defendants appealed. Poliner cross-appealed but subsequently dismissed his appeal.

II. Standard of Review

We review the denial of motion for judgment as a matter of law *de novo.*[16] A party is entitled to judgment as a matter of law when "a reasonable jury would not have a legally sufficient evidentiary basis to find for the party on that issue."[17] "In entertaining a Rule 50 motion for judgment as a matter of law the court must review all of the evidence in the record, draw all reasonable inferences in favor of the nonmoving party, and may not make credibility determinations or weigh the evidence."[18] "Nonetheless, '[i]f the facts and inferences point so strongly and overwhelmingly in favor of the moving party that the reviewing court believes that reasonable jurors could not have arrived at a contrary verdict, then we will conclude that the motion should have been granted.'"[19]

III. Health Care Quality Improvement Act

Congress passed the Health Care Quality Improvement Act because it was concerned about "[t]he increasing occurrence of medical malpractice and the need to improve the quality of medical care," and because "[t]here is a national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance."[20] Congress viewed peer review as an important component of remedying these problems, but recognized that lawsuits for money damages dampened the willingness of people to participate in peer review.[21] Accordingly, Congress "grant[ed] limited immunity from suits for money damages to participants in professional peer review actions."[22]

---

[16] *Palasota v. Haggar Clothing Co.,* 499 F.3d 474, 480 (5th Cir. 2007).

[17] Fed. R. Civ. P. 50(a).

[18] *Ellis v. Weasler Eng'g, Inc.,* 258 F.3d 386, 337 (5th Cir. 2001).

[19] *Dixon v. Wal-Mart Stores, Inc.,* 330 F.3d 311, 313-314 (5th Cir. 2003) (quoting *Resolution Trust Corp. v. Cramer,* 6 F.3d 1102, 1109 (5th Cir. 1993)).

When a "professional review action" as defined by the statute meets certain standards, the HCQIA provides that participants in the peer review "shall not be liable in damages under any law of the United States or of any State (or political subdivision thereof) with respect to the action."[23] The statute establishes four requirements for immunity:

> For purposes of the protection set forth in section 11111(a) of this title, a professional

---

[20] 42 U.S.C. § 11101(1), (2).

[21] *See Singh v. Blue Cross / Blue Shield of Mass., Inc.*, 308 F. 3d 25, 31 (1st Cir. 2002) ("Before passage of the HCQIA in 1986, threats of antitrust action and other lawsuits often deterred health care entities from conducting effective peer review.").

[22] *Mathews v. Lancaster Gen. Hosp.*, 87 F.3d 624, 632 (3d Cir. 1996).

[23] 42 U.S.C. § 11111(a); *see also id.* § 11151(9) (defining "professional review action"). The act includes exceptions for certain civil rights actions that are not at issue here. *See id.* § 11111(a).

> review action must be taken--
>
> (1) in the reasonable belief that the action was in the furtherance of quality health care,
>
> (2) after a reasonable effort to obtain the facts of the matter,
>
> (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
>
> (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).[24]

"The Act includes a presumption that a professional review [action] meets the standards for immunity, 'unless the presumption is rebutted by a preponderance of the evidence.'"[25] We agree with our sister circuits that the HCQIA's "reasonableness requirements were intended to create an objective standard of performance, rather than a subjective good faith standard."[26]

---

[24] *Id.* § 11112(a).

[25] *Mathews,* 87 F.3d at 633 (quoting 42 U.S.C. § 11112(a)).

[26] *Bryan v. James E. Holmes Reg'l Med. Ctr.*, 33 F.3d 1318, 1323 (11th Cir. 1994); *see also Singh,* 308 F.3d at 32 ("Our sister circuits have uniformly applied all the sections of § 11112(a) as objective standards. We apply these objective standards here."

A.

HCQIA immunity extends to "professional review actions." The Act defines a "professional review action" in part as

> an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician.[27]

(citations omitted)); *Sugarbaker v. SSM Health Care,* 190 F.3d 905, 912 (8th Cir. 1999) ("Further, we have held that the reasonableness requirements contained in section 11112(a) necessitate an objective inquiry."); *Brown v. Presbyterian Healthcare Servs.,* 101 F.3d 1324, 1333 (10th Cir. 1996) ("Courts apply an objective standard in determining whether a peer review action was reasonable under 42 U.S.C. § 11112(a)."); *Mathews,* 87 F.3d at 635 ("We agree with our sister circuits that § 11112(a) imposes an objective standard."); *Smith v. Ricks,* 31 F.3d 1478, 1485 (9th Cir. 1994) (explaining that "the 'reasonableness' requirements of § 11112(a) were intended to create an objective standard, rather than a subjective standard"). We previously indicated in an unpublished opinion that the "reasonableness" requirements impose an objective standard. *See Doe v. La. Psychiatric Med. Ass'n,* No. 96-30232, 1996 WL 670414, at *3 (5th Cir. Oct. 28, 1996).

[27] 42 U.S.C. § 11151(9).

The jury was charged that the May 14 abeyance and the extension of the abeyance were both professional review actions. We agree.

Both restrictions on Poliner's cath lab privileges meet the substantive elements of this definition. While there could be no extension of the abeyance without the initial abeyance, the extension of the abeyance resulted from an independent decision that another period of restriction was needed. To put it differently, the May 14 abeyance and the extension, although imposing the same substantive restrictions, enjoyed distinct justification and in this sense independently limited Poliner's privileges.[28] Thus, we evaluate the abeyance and the extension separately for compliance with § 11112(a).

To be clear, the abeyances are temporary restrictions of privileges, and we use that terminology, which comes from the Medical Staff bylaws, in our discussion; but for the purposes of HCQIA immunity from money damages, what matters is that the restriction of privileges falls within the statute's definition of "peer review action," and what we consider is whether these "peer review actions" satisfy the HCQIA's standards, and not whether the "abeyances" satisfy the bylaws.

---

[28] *Cf. Mathews*, 87 F.3d at 634 ("The definition of 'professional review action' encompasses decisions or recommendations by peer review bodies that directly curtail a physician's clinical privileges or impose some lesser sanction that may eventually affect a physician's privileges."); *Mathews v. Lancaster Gen. Hosp.*, 883 F. Supp. 1016, 1027 (E.D. Pa. 1995) (explaining that "the term 'professional review action' refers to the decision that results from a review of the facts obtained"); *Fobbs v. Holy Cross Health Sys. Corp.*, 789 F. Supp. 1054, 1065 (E.D. Cal. 1992) (explaining that the § 11112(a) standards "apply to discrete decisions, not to an ongoing course of conduct").

We deal with one other preliminary matter now. The decision to extend the abeyance was made after the ad hoc committee reported the results of its review to Knochel and the IMAC; however, because of the district court's pre-trial order of July 7, the jury did not learn of this. This does not impede our consideration of the evidence because the district court's summary judgment and July 7 orders establish the relevant historical facts[29] and the propriety of the ad hoc committee review for HCQIA purposes. The district court found that the ad hoc committee members were entitled to HCQIA immunity, and more to the point, the ad hoc committee's review undergirded the grant of HCQIA immunity for the June 12 suspension. Neither of the orders has been challenged on appeal. They are the law of the case.

B.

We begin with whether each peer review action was taken "in the reasonable belief that the action was in the furtherance of quality health care." It is plain that they were by the controlling standards. Other circuits have explained, as relevant under the facts of this case, that "[t]he 'reasonable belief standard of the HCQIA is satisfied if 'the reviewers, with the information available to them at the time of the professional review action, would reasonably have concluded that their action would restrict incompetent behavior or would protect patients."[30] "[T]he Act does not require that the professional review result in an actual improvement of the quality of health care,"[31] nor does it require that the conclusions reached by the reviewers were in fact correct.[32] It bears emphasizing that "the good or bad faith of the reviewers is irrelevant";[33] rather it is an objective inquiry in which we consider the totality of the circumstances.[34]

---

[29] It is not clear whether the committee concluded that Poliner gave substandard care in 26 or 29 cases. Some evidence and the district court's summary judgment order states that it was 29 cases, while the minutes from the IMAC meeting on May 27 list 26 cases. For our purposes, it makes no difference whether the number is 26 or 29.

It is indisputable that Poliner's treatment of Patient 36 raised serious questions about what had happened and why. Missing the LAD was a critical diagnostic error, made all the more troubling by the fact that Das and Levin saw the LAD; indeed, Poliner described the LAD as obvious and clear in his addendum. The concerns that flow from the LAD are amplified by the problems with Poliner's other patients that had been brought to Knochel's attention. It was in relatively quick succession that Knochel was presented with separate cases that called into question Poliner's medical judgment. That Poliner had over 20 years of experience and an apparently clean record before these cases only serves to heighten the concern: why was this experienced physician now having these problems? On May 14, there was ample basis for concern.

---

[30] *Meyers v. Columbia/HCA Healthcare Corp.*, 341 F.3d 461, 468 (6th Cir. 2003) (quoting *Bryan*, 33 F.3d at 1323).

[31] *Imperial v. Suburban Hosp. Ass'n, Inc.*, 37 F.3d 1026, 1030 (4th Cir. 1994); *see also Meyers*, 341 F.3d at 468 (same).

[32] *See Imperial*, 37 F.3d at 1030 ("But more importantly to the issue at hand, even if Imperial could show that these doctors reached an incorrect conclusion on a particular medical issue because of a lack of understanding, that does not meet the burden of contradicting the existence of a *reasonable belief* that they were furthering health care quality in participating in the peer review process.").

[33] *Brader v. Allegheny Gen. Hosp.*, 167 F.3d 832, 840 (3d Cir. 1999).

[34] *Imperial*, 37 F.3d at 1030.

The ad hoc committee's review, upon which the extension of the abeyance rested, speaks for itself. A group of six cardiologists reviewed 44 of Poliner's cases and concluded that he gave substandard care in more than half of the cases. We conclude that, as to both peer review actions, the belief that temporarily restricting Poliner's cath lab privileges during an investigation would further quality health care was objectively reasonable.

Poliner defends the jury's verdict by arguing that the evidence demonstrates that had Poliner "actually administered the purported 'care' demanded by the critics, he would have affirmatively *endangered* his patients." Setting aside the fact that the evidence is not so unequivocal, this argument suffers from two interrelated flaws. First, our inquiry focuses on the information available to Defendants when they made the critical decisions. Defendants did not have the benefit of post-hoc expert analyses at that time.[35] Second, this focuses on whether Defendants' beliefs proved to be *right*. But the statute does not ask that question; rather it asks if the beliefs of Poliner's peers were objectively reasonable under the facts they had at the time.[36] If a doctor unhappy with peer review could defeat HCQIA immunity simply by later presenting the testimony of other doctors of a different view from the peer reviewers, or that his treatment decisions proved to be "right" in their view, HCQIA immunity would be a hollow shield.

---

[35] *See Singh,* 308 F.3d at 41 (explaining that "[t]he appropriate 'inquiry is whether the decision was reasonable in light of the facts known at the time the decision was made, not in light of facts later discovered" (quoting *Sklaroff v. Allegheny Health Educ. Research Found.*, No. Civ. A. 95-4758, 1996 WL 383137, at *9 (E.D. Pa. July 8, 1996))); *Sugarbaker,* 190 F.3d at 916-17 (explaining that expert opinions prepared for litigation did not rebut the presumption because the opinions were not known at the time the peer review action was taken).

[36] *See Lee v. Trinity Lutheran Hosp.*, 408 F.3d 1064, 1071 (8th Cir. 2005) ("Even if Dr. Lee could show that 'the [peer review actions] reached an incorrect conclusion . . . [that] does not meet the burden of contradicting the existence of a reasonable belief that [the hospital] w[as] furthering health care quality.'" (quoting *Sugarbaker,* 190 F.3d at 916)); *Meyers,* 341 F.3d at 469 n.5 ("Our review, however, is not directed at whether each of the complaints were undisputedly true, but whether Defendants acted reasonably in considering and relying upon them."); *Sugarbaker,* 190 F.3d at 913 (explaining that such an argument "miss[es] the mark" because "[t]he focus of our inquiry is not whether the Executive Committee's initial concerns ultimately proved to be medically sound); *Mathews,* 87 F.3d at 636 n.9 ("While the conflicting reports raise an issue of fact as to whether Mathews provided acceptable care, they do not call into question whether the Board's decision in relying on the Wilson report was reasonable.").

Poliner's urging of purported bad motives or evil intent or that some hospital officials did not like him provides no succor. We have serious doubts that Poliner proved that the restrictions resulted from anti-competitive motives, and more to the point, the inquiry is, as we have explained, an objective one. Our sister circuits have roundly rejected the argument that such subjective motivations overcome HCQIA immunity,[37] as do we.

C.

"The HCQIA does not require the ultimate decisionmaker to investigate a matter independently, but requires only a 'reasonable effort to obtain' the facts."[38] We consider "the totality of the process leading up to" the professional review action.[39]

---

[37] *See, e.g.*, *Sugarbaker,* 190 F.3d at 914 ("In the HCQIA immunity context, the circuits that have considered the issue all agree that the subjective bias or bad faith motives of the peer reviewers is irrelevant."), *Mathews*, 87 F.3d at 635 (explaining that other circuits "have held that a defendants subjective bad faith is irrelevant under § 11112(a) and have upheld a finding of immunity if, on the basis of the record, the court could conclude that the professional review action would further quality health care"); *Bryan,* 33 F.3d at 1335 ("Moreover, Bryan's 'assertions of hostility do not support his position [that the Hospital is not entitled to the HCQIA's protections] because they are irrelevant to the reasonableness standards of § 11112(a). The test is an objective one, so bad faith is immaterial The real issue is the sufficiency of the basis for the [Hospital's] actions.'" (quoting *Austin v. McNamara,* 979 F.2d 728, 734 (9th Cir. 1992))).

[38] *Gabaldoni v. Wash. County Hosp. Ass'n,* 250 F.3d 255. 261 (4th (Cir. 2001).

No reasonable jury could conclude that Defendants failed to make a "reasonable effort to obtain the facts." Prior to May 14, Patients 3, 9, and 18 had been reviewed by the CRRC, which identified the care issues involved and forwarded the cases to Knochel. Each of these cases was reviewed by a cardiologist for Knochel and the IMAC. As to Patient 36, Knochel spoke with Weinmeister, Das, Levin, and Harper. Levin reviewed the films and spoke with Poliner briefly about the case, while Harper reviewed the patient's chart and films. Das saw the LAD while the procedure was occurring and spoke with Poliner. Weinmeister had treated the patient post-procedure. And, as to the abeyance extension, Knochel relied on the review of 44 cases conducted by the ad hoc committee. As explained above, the district court's summary judgment established the propriety of the ad hoc committee review, and that remains unchallenged, for good reason. Knochel was entitled to rely on the information provided to him by the other doctors,[40] and there is nothing to suggest that the information was facially flawed or otherwise so obviously deficient so as to render Defendants' reliance "unreasonable."[41]

---

[39] *Mathews*, 87 F. 3d at 637; *see also Meyers*, 341 F.31 at 469 (same).

[40] *See Gabaldoni,* 250 F.3d at 261 (explaining that "it was permissible for the Board to rely on the reports and investigations of the various committees . . . in rendering its decision"); *Bryan,* 33 F.3d at 1335 (same).

Poliner urges that omissions in the investigation and Knochel's admission at trial that further investigation was necessary before Poliner's privileges could be summarily suspended-that is, there was insufficient evidence to denominate Poliner a "present danger" under the bylaws-support the jury's findings that a "reasonable effort" was lacking. As to the former, Poliner was entitled to a *reasonable* effort, not a perfect effort.[42]

Poliner's latter argument is unavailing because HCQIA immunity is not coextensive with compliance with an individual hospital's bylaws. Rather, the statute imposes a uniform set of national standards. Provided that a peer review action as defined by the statute complies with those standards, a failure to comply with hospital bylaws does not defeat a peer reviewer's right to HCQIA immunity from damages.[43]

---

[41] *Cf. Brader,* 167 F.3d at 843 (explaining that "the reports of Diamond and Ochsner were not so obviously mistaken or inadequate as to make reliance on them unreasonable").

[42] *Singh,* 308 F.3d at 43.

[43] *See Meyers,* 341 F.3d at 469-70 (rejecting an argument that failure to comply with hospital bylaws defeated immunity because "even assuming LMH did violate the bylaws, the notice and procedures provided complied with the HCQIA's statutory 'safe harbor'"); *Ricks,* 31 F.3d at 1487 n.8 (rejecting an argument that violations of state law and professional organization guidelines defeat HCQIA immunity "because once the immunity provisions of the HCQIA are met, defendants 'shall not be liable in damages

It bears emphasizing that this does not mean that hospitals and peer review committees that comply with the HCQIA's requirements are free to violate the applicable bylaws and state law. The HCQIA does not gainsay the potential for abuse of the peer review process. To the contrary, Congress limited the reach of immunity to money damages. The doors to the courts remain open to doctors who are subjected to unjustified or malicious peer review, and they may seek appropriate injunctive and declaratory relief in response to such treatment.[44] The immunity from money damages may work harsh outcomes in certain circumstances, but that results from Congress' decision that the system- wide benefit of robust peer review in rooting out incompetent physicians, protecting patients, and preventing malpractice outweighs those occasional harsh results; that giving physicians access to the courts to assure procedural protections while denying a remedy of money damages strikes the balance of remedies essential to Congress' objective of

---

under any law of the United States or of any State' based on a professional review action" (quoting § 11111(a)(l))); *Bakare v. Pinnacle Health Hosps., Inc.*, 469 F. Supp. 2d 272, 290 n.33 (M.D. Pa. 2006) ("HCQIA immunity attaches when the reviewing body satisfies the requirements *under HCQIA*, regardless of its own policies and procedures.").

[44] *Sugarbaker*, 190 F.3d at 918; *see also Singh*, 308 F.3d at 44 ("HCQIA immunity only covers liability for damages. It does not shield covered defendants from suit and other forms of relief."); *Imperial*, 37 F.3d at 1031 (explaining that "the actual protection given by the Act is limited to damages"). To the extent we suggested otherwise in *Doe*, *see* 1996 WL 670414, at *4, we decline to follow, and are not bound by, that unpublished opinion, *see* 5th Cir. 47.5.4 (providing that "[u]npublished opinions issued on or after January 1, 1996, are not precedent").

vigorous peer review.[45] The doctor may not recover money damages, but can access the court for other relief preventive of an abusive peer review. It is no happenstance that this congressional push of peer review came in a period of widespread political efforts at the state level to achieve tort reform and protect medical doctors from the debilitating threat of money damages. It would have been quixotic at best If those efforts were accompanied by tolerance of money damages suits by doctors facing peer review-where tort reformers assured that discipline of doctors would be found.

D.

Section 11112(a)(3) imposes certain procedural requirements, namely that a peer review action is taken "after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances." Section 11112(b) provides a "safe harbor" set of procedures that, if given, means that the "health care entity is deemed to have met the adequate notice and hearing requirement." Finally, § 11112(c) provides,

> (c) Adequate procedures in investigations or health emergencies

---

[45] *See Imperial*, 37 F.3d at 1028 ("To assure that hospitals and doctors cooperate with the system and engage in meaningful professional review, Congress found it essential to provide qualified immunity from damages actions for hospitals, doctors, and others who participate in the professional review process.").

> For purposes of section 11111(a) of this title, nothing in this section shall be construed as--
>
> (1) requiring the procedures referred to in subsection (a)(3) of this section--
>
> > (A) where there is no adverse professional review action taken, or
> >
> > (B) in the case of a suspension or restriction of clinical privileges, for a period of not longer than 14 days, during which an investigation is being conducted to determine the need for a professional review action; or
>
> (2) precluding an immediate suspension or restriction of clinical privileges, subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action may result in an imminent danger to the health of any individual.

The peer review actions satisfy the HCQIA's procedural requirements.

The May 14 restriction falls squarely within § 11112(c)(1)(B)'s scope. The abeyance was a restriction of privileges that was imposed to allow for an investigation to determine whether other action, such as a suspension, was necessary. Poliner urges that the provision does not apply because the restriction lasted for 15 days, one day longer than is permissible. We are not persuaded. The ad hoc committee completed its review and reported its results to Knochel and the

IMAC on May 27. Upon receipt of the ad hoc committee report, Defendants had an objectively reasonable basis to take another peer review action. The IMAC decided that same day that a further restriction of Poliner's privileges was necessary. For immunity purposes it is of no moment that they requested Poliner's consent to the extension of the abeyance on May 29, the purported fifteenth day, because the decision to further restrict his privileges was made within the required 14 days.

We conclude that the extension of the abeyance falls within § 11112(c)(2)'s curtilage,[46] and in any event, Defendants imposed the restriction after procedures that were fair to Poliner under the circumstances. The "emergency" provision requires only that a failure to act "may result in an imminent danger to the health of any individual." That the ad hoc committee concluded that Poliner gave substandard care in half of the cases reviewed, and considering the seriousness of the diagnostic error with Patient 36 and the serious risks that attend cardiac catheterizations, Defendants were fully warranted in concluding that failing to impose further temporary restrictions "may result" in an imminent danger. Poliner contends that this provision applies in "extraordinary cases in which a physician suddenly becomes impaired or grossly incompetent." Poliner cites no authority for this proposition, and the plain language of the statute is not so limited. Moreover, authority from our sister circuits and the district courts conclude that the provision is not so narrow,[47] as does an unpublished decision from our court.[48]

---

[46] The parties dispute whether § 11112(c)(2) relieves compliance with all of § 11112(a)'s standards or is limited to § 11112(a)(3)s "notice and hearing" requirement. We need not, and do not, wade into this dispute because we conclude that the extension of the abeyance satisfies the requirements of 11112(a)(1), (2), and (4).

---

[47] *See Sugarbaker,* 190 F.3d at 917 (indicating that the Executive Committee's decision to impose a "precautionary suspension" would fall under the emergency provision after a clinical review committee reviewed 24 of the doctor's patients and reported multiple areas of concern); *Brader,* 167 F.3d at 836-37, 842 (holding that a summary suspension of a surgeon's privileges to perform an operation fell under the emergency provision where a review of the mortality rates for the procedure at the hospital showed that the surgeon was responsible for half of the mortalities, and an outside reviewer reported numerous complications and instances of "poor surgical judgment"); *Johnson v. Christus Spohn,* No. C-06-138, 2008 WL 375417, at *12 (S.D. Tex. Feb. 8, 2008) ("Based on the purportedly negligent treatment of RM [who eventually died], the Court has little trouble finding Dr. Johnson's summary suspension was appropriately based on the reasonable belief he failed to care for a patient and thus may have represented an imminent danger to the health of an individual."); *Schindler v. Marshfield Clinic,* No. 05-C-705-C, 2006 WL 2944703, at *13 (W.D. Wisc. Oct. 12, 2006) (explaining that, where a surgeon "was performing surgery, a surgical instrument slipped and plaintiffs patient was rendered quadriplegic for an unspecified period of time," and the surgeon was temporarily suspended during an investigation, the emergency provision was "satisfied"); *Bakare,* 469 F. Supp. 2d at 282, 289 & n.31 (holding that the emergency provision applied to a precautionary suspension that was imposed after an outside reviewer reviewed ten of the plaintiffs cases and concluded that "beyond a reasonable degree of medical certainty [Dr. Bakare's] medical management falls below the established standards"): *Pfenninger v. Exempla, Inc.,* 116 F. Supp. 2d 1184, 1202 (D. Colo. 2000) (concluding that the emergency provision was applicable where "the Executive Committee found that Dr. Pfenninger had exercised poor judgment in three recent cases; that he had a history of similar problems, and that summary suspension was 'necessary to protect patients'").

Poliner received the "subsequent notice and hearing or other adequate procedures" that the provision contemplates. To the point, the district court ruled at summary judgment that, as to the June 12 suspension, Poliner received notice and hearing adequate to satisfy the HCQIA. That ruling, which has not been challenged, establishes that Poliner received adequate process for purposes of the "emergency" provision.

Our review confirms this, and further leads us to conclude that the extension was imposed "after such other procedures as are fair to the physician under the circumstances." The May 14 letter provided notice to Poliner of the peer review, which patient triggered it, the other patients then-of concern, that an ad hoc committee review would be taken and a general description of how that review would be conducted, and finally that Poliner would have "an opportunity to meet with the PMAC] and me in person to respond to or clarify any clinical concerns that could result in a recommendation for corrective action prior to that action being taken." Poliner and his lawyer knew what was happening and why before the extension.

The ad hoc committee's conclusions justify Defendants' decision to impose another period of the same restrictions without immediately giving a hearing. The committee review raised serious problems with Poliner's cases, and rather than acting precipitously, Defendants sought out further information. It is difficult to conceive of a meaningfully different response from Defendants. Upon receipt of the ad hoc committee's review, it would have been untenable to restore full privileges while a hearing was scheduled and Poliner was given time to prepare. Had Defendants immediately held a hearing, there would have been no opportunity for Poliner to review the cases at issue, and we have no doubt that we would be considering whether such a hearing was "fair." Further informing our analysis is the fact that Poliner had engaged counsel prior to the extension of the abeyance. It bears emphasizing that the restriction on privileges was temporary in nature and limited in scope, tailored to the objective facts before the hospital officials. Poliner received "fair" procedures under these circumstances.

---

[48] *See Payne v. Harris Methodist HEB,* No. 01-10212, 2002 WL 1396969, at *1 n. 1 (5th Cir. June 7, 2002) (holding, in considering the emergency provision, that "[g]iven the serious allegations of incompetence made against Payne, we agree with the district court that the hospital was permitted to suspend him temporarily while sorting out the truth of the allegations").

Once the decision was made, Poliner was quickly notified that the extension was needed, given further details of the ad hoc committee review, and told again that he would have an opportunity to address the IMAC. Ten days after extending the restrictions, a date for a hearing was set and Poliner was notified of the hearing, told which patients had been reviewed and the concerns in those cases, and given access to the patient records. The hearing, in which Poliner personally participated, was promptly held on June 11.

This case demonstrates how the process provisions of the HCQIA work in tandem: legitimate concerns lead to temporary restrictions and an investigation; an investigation reveals that a doctor may in fact be a danger; and in response, the hospital continues to limit the physician's privileges. The hearing process is allowed to play out unencumbered by the fears and urgency that would necessarily obtain if the physician were midstream returned to full privileges during the few days necessary for a fully informed and considered decision resting on all the facts and a process in which the physician has had an opportunity to confront the facts and give his explanations. The interplay of these provisions may work hardships on individual physicians, but the provisions reflect Congress' balancing of the significant interests of the physician and "the public health ramifications of allowing incompetent physicians to practice while the slow wheels of justice grind."[49] Defendants satisfied the notice and hearing requirements, and no reasonable jury could conclude otherwise.

E.

Finally, we consider whether each peer review action was taken "in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts." "Our analysis under § 11112(a)(4) closely tracks our analysis under § 11112(a)(1)."[50] In both instances, the temporary restrictions were "tailored to address the health care concerns" that had been raised[51] –procedures in the cath lab–leaving untouched Poliner's other privileges. Nor was the information relayed to Knochel "so obviously mistaken or inadequate as to make reliance on [it] unreasonable."[52] There was an objectively reasonable basis for concluding that temporarily restricting Poliner's privileges during the course of the investigation was warranted by the facts then known, and for essentially the reasons given above, we hold that Defendants satisfy this prong.

---

[49] *Rogers v. Columbia/HCA of Cent. La., Inc.*, 971 F. Supp. 229, 236 (W.D. La. 1997).

[50] *Brader*, 167 F.3d at 843; *see also Meyers*, 341 F.3d at 471 (same); *Singh*, 308 F.3d at 38 n. 13 (same); *Sugarbaker*, 190 F.3d at 916 (same).

To allow an attack years later upon the ultimate "truth of judgments made by peer reviewers supported by objective evidence would drain all meaning from the statute. The congressional grant of immunity accepts that few physicians would be willing to serve on peer review committees under such a threat; as our sister circuit explains, "'the intent of [the HCQIA] was not to disturb, but to reinforce, the preexisting reluctance of courts to substitute their judgment on the merits for that of health care professionals and of the governing bodies of hospitals in an area within their expertise.'"[53] At the least, it is not our role to re-weigh this judgment and balancing of interests by Congress.

IV. Conclusion

Not only has Poliner failed to rebut the statutory presumption that the peer review actions were taken in compliance with the statutory standards, the evidence independently demonstrates that the peer review actions met the statutory requirements. Because Defendants are immune under the HCQIA, we have no occasion to consider Defendants' other substantial arguments that we must reverse and render judgment based on state law immunity[54] and because Poliner failed to prove the substantive elements of his claims. One of the largest difficulties lies in causation, that is, whether Poliner proved that any of the purported damages were caused by the abeyance and abeyance extension as opposed to the June 12 suspension that was immunized before trial. Nor need we reach the compelling arguments that, at the very least, we would have to reverse and remand for a new trial because of the jury's excessive verdict[55] and manifest trial errors.

---

[51] *Mathews*, 87 F.3d at 638.

[52] *Id.*

[53] *Lee*, 408 F.3d at 1073 (quoting *Bryan*. 33 F.3d at 1337).

We REVERSE the judgment of the district court and RENDER judgment for Defendants.

---

[54] *See* Tex. Occ. Cock -Ann. § 160.010.

[55] *See Wells v. Dallas Indep. Sch. Dist.*, 793 F.2d 679, 683-84 (5th Cir. 1986) (explaining that "when an award is 'so exaggerated as to indicate bias, passion, prejudice, corruption, or other improper motive,' remittitur is inadequate and the only proper remedy is a new trial" (quoting *Caldarera v. E. Airlines, Inc.*, 705 F.2d 778, 784 (5th Cir. 1983))).

APPENDIX B

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF TEXAS DALLAS DIVISION

CIVIL ACTION NO. 3:00-CV-1007-P

[Filed October 13, 2006]

LAWRENCE R. POLINER, M.D. and)
LAWRENCE R. POLINER, M.D., P.A.,)
Plaintiffs,)
)
v.)
)
TEXAS HEALTH SYSTEMS, a Texas)
non-profit corporation, d/b/a)
PRESBYTERIAN HOSPITAL OF)
DALLAS, and JAMES KNOCHEL, M.D.,)
Defendants.)
)

AMENDED MEMORANDUM OPINION AND ORDER

Now before the Court are (1) Defendants' Texas Health Systems (Presbyterian Hospital of Dallas) and James Knochel, M.D.'s Motion for Remittitur, filed September 16, 2005; (2) Defendants Texas Health Systems (Presbyterian Hospital of Dallas) and James Knochel, M.D.'s Motion for a New Trial, filed

September 16, 2005; (3) Plaintiffs' Post-trial Petition for Attorneys' Fees, Expenses and Costs; and (4) Defendants' motion for settlement credit, filed May 26, 2006[1] After careful consideration of the Parties' briefing and the applicable law, the Court hereby DENIES Defendants' Motion for a New Trial, GRANTS in PART Defendants' Motion for Remittitur, DENIES in part as MOOT and DENIES in part as premature Plaintiffs' Post-trial Petition for Attorneys' Fees, Expenses and Costs, and DENIES Defendants' motion for settlement credit.

MOTION FOR NEW TRIAL

A. ERRONEOUS EXCLUSION OF EVIDENCE AT TRIAL.

In their Motion for a New Trial,[2] Defendants Texas

---

[1] In its Order dated March 26, 2006, the Court denied in part Defendants' Motion for a New Trial. The remainder of that motion - that portion concerning damages - will be considered herein.

[2] Local Rule 7.1(d) requires that a motion be accompanied by a brief that sets forth the movant's contentions of facts and/or law, and argument and authorities. As Defendants are aware, motions shall concisely articulate the grounds therefor, whereas the brief is to contain the statement of facts, legal theories, legal arguments, and legal analysis. The brief should contain all the information the Court needs to make its determination (with the exception of evidence.) Local Rule 7.2(c) states that a brief must not exceed twenty-five pages. Defendants filed a twenty-one page brief along with a fifty-five page motion for a new trial. Certainly, a fifty-five page motion is not a concise articulation of the ground therefor. Defendants' attempt to present fifty-five pages of facts

Health Systems (Presbyterian Hospital of Dallas) ("Presbyterian" or "the Hospital") and James Knochel, M.D. ("Knochel") (collectively,"Defendants") argue that the Court's erroneous admission and exclusion of certain evidence warrants reversal and a new trial. (Defs.' Br. at 16-17.) Specifically, Defendants argue that the Court erroneously excluded evidence establishing that in November 1998, the Hearing Committee upheld Dr. Poliner's June 1998 summary suspension and found it justified. (*citing* Trial Tr. Vol. 9 at 2099-2103; Defs.' App. at 95.)

At the summary judgment stage, the Court found as a matter of law that the June 1998 suspension was lawful and dismissed several defendants from the case on that basis. Consequently, the theory of the case narrowed to the single issue of whether the May 1998 suspension/abeyance was lawful. Because the jury was only to consider whether the circumstances surrounding the May abeyance/suspension gave rise to a cause of action and damages, the Court ruled that the fact that the Hearing Committee upheld the June summary suspension in November was deemed irrelevant and inadmissible.

The Court rejects Defendants' conclusory argument that the Court's decision to exclude such evidence was harmful error. Defendants offer no valid legal basis for reversing the ruling and therefore the Court declines to do so.

---

and legal discussion in a motion is clearly an impermissible effort to circumvent the page limits.

B. JURY CHARGE ERROR.

Defendants also argue they are entitled to a new trial because of several errors in the jury charge. First, Defendants argue that the Court erred in refusing to ask the jury to apportion the damages among each defendant. Defendants maintain that Section 33.003 of the Texas Civil Practices and Remedies Code, which is the Proportionate Responsibility Statute, mandates that the jury shall determine the percentage of responsibility of each defendant. (Defs.' Br. at 18.)Defendants conclude that "[b]ecause of the jury's failure to apportion damages, it is impossible to determine whether the jury intended to apportion damages according to the amounts awarded, or awarded damages against each defendant for the same injury." (Defs.' Br. at 18-19.)

Section 33.003 provides that

> [t]he trier of fact, as to each cause of action asserted, shall determine the percentage of responsibility, stated in whole numbers, for the following persons with respect to each person's causing or contributing to cause in any way the harm for which recovery of damages is sought, whether by negligent act or omission, by any defective or unreasonably dangerous product, by other conduct or activity that violates an applicable legal standard, or by any combination of these: (1) each claimant; (2) each defendant; (3) each settling person; and (4) each responsible third party . . .

Tex. Civ. Prac. & Rem. Code § 33.003 (Vernon 1997

Supp. 2005). Although Defendants did request an apportionment question in the jury charge, Defendants did not provide the Court with any legal authority supporting their request. (Trial Tr. Vol. 10 at 2389-90.) They never cited to the Texas Proportionate Liability Statute or any other legal source.

In the Court's Charge to the Jury, the Court specifically instructed the jury to consider each defendant separately and not to include damages as to one defendant in assessing damages against any other defendant. (*See* Jury Question No. 11.) The jury charge listed each defendant separately and provided blanks next to each defendant's name for each element of recovery (*e.g.*, loss of earnings, injury to career and reputation, mental anguish). The fact that the jury returned a verdict with different amounts for each defendant with respect to injury to career/reputation and mental anguish indicates that the jury apportioned the responsibility for the damages among the several defendants. Because the jury did apportion the damages among the defendants, the Court finds there was no harmful error.

With respect to loss of earnings, the evidence at trial established that Plaintiffs' lost earnings amount was $10,526.55. (*See* Trial Tr. Vol. 11 at 2544.) The jury entered that entire amount next to each defendant's name. The fact that the jury returned a verdict with the same amount for each defendant with respect to lost earnings indicates that the jury believed that each defendant's conduct proximately caused Plaintiffs to lose the entire lost earnings amount and that all defendants should be held liable for that amount. The Court concludes that the jury intended to hold all Defendants responsible for one lost earnings amount, and consequently there is no harmful error.[3]

Defendants also argue that a new trial is required because the jury was not asked to apportion the damages between Plaintiffs Dr. Poliner and his Professional Association. (Defs.' Br. at 13.) They cite to section 71.010 of the Texas Civil Practices and Remedies Code which states that damages shall be divided by the jury among the individuals who are entitled to recovery. (Defs.'Br. at 13.)

Defendants did not request apportionment among Plaintiffs at any time during trial, in any motion, or at the jury charge conference. Not only has this argument been waived, it is disingenuous and wholly without merit. Chapter 71 of the Texas Civil Practices and Remedies Code is Texas' Wrongful Death Statute and Section 71.010 applies only in wrongful death cases.

Second, Defendants argue that the Court erred in failing to include an agency issue or instruction in the jury charge explaining that Presbyterian can only be liable through its agents and employees. (Defs.' Br. at 19.)[4] They go on to state in a conclusory fashion that

---

[3] Because the defendants cannot be held jointly and severally liable for this amount, the Court hereby assesses $5263.28 against Dr. Knochel and $2631.64 against Presbyterian. These amounts were calculated in accordance with the ratio used by the Jury to assess the actual non-economic damages. The Court considers the settlement amounts paid by Drs. Levin and Harper to include their portion of the economic damages owed.

[4] This issue, while unrelated to damages, was not resolved in the Court's March 26, 2006 Order.

"Plaintiffs failed to establish that the acts of [Dr. Knochel] fell within the scope of [Dr. Knochel's] general authority and were in furtherance of Presbyterian's business and for the accomplishment of the object for which [Dr. Knochel] was hired." (Defs.' Br. at 19.) The Court disagrees.

First, the jury charge did include an agency instruction in not one, but two instances. (*See* Court's Charge to the Jury at 2, 47.) Second, the evidence at trial established unequivocally that Dr. Knochel's unlawful conduct fell within the scope of his authority and was in furtherance of Presbyterian's business and for the accomplishment of the object for which Dr. Knochel was hired. In fact, there was no evidence to the contrary. Moreover, the jury's finding of liability against the Hospital was appropriate in light of the testimony and conduct of the Hospital's Vice-President for Medical Staff Affairs and its President, who supported Dr. Knochel's conduct at the time it occurred and at trial. Those administrators testified that they believed Dr. Knochel acted fairly and appropriately under the circumstances.

Defendants also argue they are entitled to a new trial because the Court erred by submitting the same damages elements multiple times, thereby presenting the danger of multiple recoveries. (Defs.' Br. at 19.) To the extent Defendants are arguing that the Court erred by submitting a damages question to the jury for each of the different causes of action, such as breach of contract, defamation, tortious interference, etc., that issue is moot because the one-satisfaction rule limits Plaintiffs' recovery to one claim. Additionally, the jury was specifically instructed to consider each defendant separately with respect to damages, thereby obviating the risk of a double recovery. The hospital administrators were consulted and agreed with the summary suspension decision and with the procedure utilized. By its verdict, the jury found Dr. Knochel the most culpable of the defendants, then the Hospital, and lastly, Drs. Levin and Harper.

For these reasons, the remainder of Defendants' Motion for a New Trial is hereby DENIED.[5]

MOTION FOR REMITTITUR

A. BACKGROUND

In an order dated March 27, 2006, this Court held that the one-satisfaction rule requires Plaintiffs to elect one of their alternative claims for entry of judgment. Accordingly, per Plaintiffs' request, the Court entered judgment on Plaintiffs' defamation claim.[6]

The jury awarded Dr. Poliner $90,010,526.55 in actual damages as compensation for the defamatory statements made against him by Defendants Knochel, Harper, Levin and Presbyterian. The Jury Charge specifically instructed the jurors to consider each defendant separately and not to include damages as to one defendant in assessing damages against any other defendant. (*See* Jury Question No. 11.)

---

[5] The issue of whether the damage awards are excessive is addressed herein as part of the Court's discussion concerning remittur.

[6] Because Plaintiffs elected for judgment on their defamation claim rather than their breach of contract claim, Plaintiffs' Post-trial Petition for Attorneys' Fees, Expenses, and Costs is hereby denied with respect to Plaintiffs' recovery of attorneys' fees. However, as the prevailing party, Plaintiffs are entitled to recover their costs. See Fed. R. Civ. P. 54(d)(1). Upon entry of judgment, Plaintiffs are entitled to resubmit their bill of costs.

With respect to Dr. Knochel, the jury awarded Dr. Poliner $10,526.55 in economic damages,$20 million in mental anguish damages and $20 million in injury to reputation and career damages. With respect to Presbyterian, the jury awarded Dr. Poliner $10,526.55 in economic damages, $15 million in mental anguish damages and $15 million in injury to reputation and career damages. The jury also found that Plaintiffs were entitled to recover exemplary damages in the amount of $110 million. The jury held Dr. Knochel responsible for $40 million and Presbyterian responsible for $50 million of that amount.

B. LEGAL PRINCIPLES FOR REMITTITUR.

In their Motion for a New Trial, Defendants argue that the actual and exemplary damages found by the jury are unsupportable and excessive such that a new trial is warranted. In the alternative, Defendants argue in their Motion for Remittitur that the jury's award of $70,010,526.55 in actual damages against Dr. Knochel and Presbyterian is excessive and contrary to right reason, thereby necessitating a remittitur.

There is a strong presumption in favor of affirming a jury award of damages. *See Hughes v. Ford Motor Co.*, 204 F. Supp. 2d 958, 964 (N.D. Miss. 2002). The court may not reverse a jury verdict for excessiveness except on the "strongest of showings." *Caldarera v. Eastern Airlines, Inc.*,705 F.2d 778, 784 (5th Cir. 1983). The jury's award is not to be disturbed unless it is entirely disproportionate to the injury sustained. *See id.* Yet, when a jury's award exceeds the bounds of any reasonable recovery, the court must grant a remittitur. *See id.* Decisions on motions for new trial and remittitur are committed to the sound discretion of the trial court. *See Westbrook v.General Tire and Rubber Co.*, 754 F.2d 1233, 1241 (5th Cir. 1985); *Hughes*, 204 F. Supp. 2d at 964.

Trial courts should employ remittitur for those verdicts that are so large as to be contrary to right reason, whereas a new trial should be ordered when the jury's damage award was infected by passion or prejudice. *See Wells v. Dallas Indep. Sch. Dist.*, 793 F.2d 679, 683-84 (5th Cir. 1986); *Smith v. City of Seven Points*, 608 F. Supp. 458, 463 (E.D. Tex. 1985). If the court believes that a remittitur is more appropriate, it must first offer the plaintiff a choice between accepting a reduction in damages or proceeding with a new trial. *See Smith*, 608 F. Supp. at 463.

In reducing the level of damages, the court may not simply substitute its opinion concerning the proper amount for that of the jury. *See id.* The rules governing remittitur vary by jurisdiction. They may be provided for specifically in a statute or court rules, or developed through case law. Texas courts determine the size of the remittitur in accordance with the judge-made "maximum recovery rule," which prescribes that the verdict must be reduced to the maximum amount the jury could properly have awarded. *See Caldarera*, 705 F.2d at 784. The court "will decline to reduce damages where the amount awarded is not disproportionate to at least one factually similar case from the relevant jurisdiction." *Lebron v. United States*, 279 F.3d 321, 326 (5th Cir. 2002). The maximum recovery rule does not limit an award to the highest amount previously entered in the jurisdiction, but instead does not become operative unless the award exceeds 133% of the highest previous recovery in the relevant jurisdiction for a factually similar case. *See id.* Because the facts of each case are different, prior damages awards are not always controlling; the rule does not apply when unique facts or circumstances are present that are not reflected within the controlling caselaw. *See id.*

If a new trial is warranted and if it is clear that the issue of damages is independent of those issues relating to liability, the new trial, if any, may be limited to the question of damages. *See Smith,* 608 F. Supp. at 465.

C. REMITTITUR/NEW TRIAL ANALYSIS.

When deciding whether it is appropriate to set either a remittitur or a new trial, the Court must resolve several issues: First, was the verdict excessive? Second, if the verdict was excessive, was the jury motivated by passion or prejudice? Third, if the verdict was excessive, but was not motivated by passion or prejudice, what was the maximum amount the jury could have awarded given the evidence submitted and the applicable law? And finally, how much should the damages be reduced in order to set a proposed remittitur?

1. Excessiveness of Verdict.

The first issue the Court must resolve is whether the verdict was excessive. With respect to economic damages, the evidence at trial reflected a total lost earning amount of $10,526.55. The jury verdict held each defendant responsible for $10,526.55, thereby indicating that the jury believed each defendant's conduct proximately caused Plaintiffs to lose the entire lost earnings amount. The Court concludes that the jury intended to hold all Defendants responsible for one lost earnings amount. This amount is not excessive.

The jury also awarded Dr. Poliner $35 million for injury to his reputation/career. Although it is difficult to calculate an amount to fairly and reasonably compensate someone for the damage to their career/reputation, the law requires juries to do so. Dr. Poliner's career was decimated by Defendants' actions. The evidence at trial established that Dr. Poliner had an impressive and unblemished career in cardiology prior to these events. Dr. Poliner attended college at Notre Dame University and studied medicine at Cornell Medical School. After doing his residency in Colorado and spending some time in the United States Air Force, Dr. Poliner went into a fellowship program at University of Texas Southwestern Medical School in cardiology, where he eventually became a faculty member. After spending some years in academia at University of Texas Southwestern Medical School and at Baylor College of Medicine, Dr. Poliner was recruited to head a heart institute in Kansas. He spent many years practicing in Kansas and spent some time practicing cardiology in Indiana. In 1996, Dr. Poliner moved to Dallas to practice medicine with a large physicians' group. He left that group in June 1997 and began his own cardiology practice with privileges at Presbyterian. According to the testimony at trial, Dr. Poliner had never had his medical license questioned, had never been asked to agree to an abeyance, and had never been sued for malpractice.

While working in Dallas at Presbyterian, Dr. Poliner practiced emergency cardiac medicine and, in an effort to build up his private practice, was relying almost solely on emergency room physician referrals for his business. While at Presbyterian, his referral base grew steadily and he was doing a large volume of work in the cath lab.

After being labeled by Defendants as a "dangerous doctor," the emergency room doctors stopped referring patients to him, lest they be blamed for sending a patient to an unsafe doctor. Consequently, Dr. Poliner was unable to sustain any kind of practice at Presbyterian. Although he had courtesy privileges at Medical City Dallas, his referral practice had dried up.

While there is no doubt that Dr. Poliner's evidence established that he suffered a massive injury to his reputation/career, there was no evidence that he suffered damages in the amount of $35 million. That amount is not reasonable and is excessive.

The jury also awarded Dr. Poliner $35 million for mental anguish suffered by Knochel's and Presbyterian's tortious conduct. Mental anguish is recoverable when it causes a substantial disruption in daily routine or a high degree of mental pain and distress. *See Bently v. Bunton*, 94 S.W.3d 561, 606 (Tex. 2002). Dr. Poliner testified that the ordeal and the ensuing litigation caused him to lose sleep, cost him time with his family, caused him to spend innumerable hours with lawyers and work on the lawsuit, disrupted his family life, distressed his children, and cost him his career. He explained that people in the medical community viewed him with disdain and he suffered great embarrassment and humiliation. Dr. Poliner's wife (who worked with Dr. Poliner) testified that Dr. Poliner's life and personality changed dramatically as a result of this ordeal. She testified that following the abeyance, he worked day and night on this matter- reviewing records, consulting with doctors for their testimony at his hospital hearing(s), making copies of documents, and hiring others to help. She testified that Dr. Poliner was no longer a confident physician who enjoyed his profession, his family, and his life. She testified that this experience made Dr. Poliner and the mood of their entire family anxious and sad.

The record leaves no doubt that Dr. Poliner suffered mental anguish as a result of Defendants' statements. Although the humiliation and mental anguish suffered by Dr. Poliner are abstract and speculative elements of damages that are not susceptible to precise calculation, the Court finds that $35 million is not a rational amount of damages based on the evidence.

The jury's punitive damage award against Defendants Knochel and Presbyterian totaled $90 million. At trial, the jury heard Dr. Knochel testify that he did not have enough information to assess whether Dr. Poliner posed a present danger to his patients at the time he asked Dr. Poliner to agree to the abeyance. Dr. Knochel threatened Dr. Poliner with suspension of his privileges if Dr. Poliner refused to sign the abeyance letter, even though "[w]e didn't determine that [Dr. Poliner] was a present threat to his patients at that particular point. That is why we asked for an abeyance to investigate it to see if he was in fact dangerous to his patients." Dr. Knochel was prepared to suspend Dr. Poliner's privileges despite the fact that he did not know whether Dr. Poliner posed a present danger to his patients. The Hospital's representative testified that this procedure was"appropriate and sanctioned." This evidence supports the jury's finding that the suspension was not undertaken in the reasonable belief that Dr. Poliner posed a present danger to the health of his patients and was in violation of the Hospital bylaws. The jury also heard Dr. Knochel testify that he informed Dr. Poliner that Dr. Poliner must agree to an abeyance of his cath lab privileges or Dr.Knochel would terminate all his hospital privileges immediately. Dr. Knochel did not offer Dr. Poliner any other options that may have been less severe. The Hospital's representative testified that this threat was "acceptable for an abeyance procedure." There was also evidence that Dr. Knochel told Dr. Poliner that he was not permitted to consult an attorney. Additionally, Dr. Poliner's medical experts testified that no reasonable hospital could have taken the action it did against Dr. Poliner except by knowingly or recklessly disregarding the medical evidence. Furthermore, there was evidence at trial that none of the Defendants would discuss the patient cases with Dr. Poliner prior to his summary suspension and that they did not provide Dr. Poliner with an opportunity to be heard or any hearing of any kind prior to his summary suspension. Although this type of malicious conduct can warrant the imposition of punitive damages, the Court finds that $90 million is excessive.

2. Jury Motivation.

Having determined that $160 million is an excessive verdict based on the evidence presented, the Court must now determine whether the jury was motivated by passion and prejudice in arriving at the total. *See Smith v. City of Seven Points*, 608 F. Supp. 458, 463 (E.D. Tex. 1985). When an award is so exaggerated as to indicate bias, prejudice, corruption, or improper motive, the only proper remedy is a new trial. *Wells v. Dallas Indep. Sch. Dist.*, 793 F.2d 679, 683-84 (5th Cir. 1986). In the alternative, if the Court determines that the verdict was contrary to right reason, but was not the product of passion or prejudice, Plaintiffs will be offered the choice between remittitur or a new trial.

Resolution of this issue requires great reliance on the discretion of the trial court. *See Smith*,608 F. Supp. at 463. Based on the judge's observation of the trial, he or she must determine whether the jury was impassioned or prejudiced against the defendants. *See id.*

There is no doubt that the size of this award clearly reflects the jury's desire to punish these Defendants and to compensate Dr. Poliner for the loss of his career. The fact that Dr. Poliner, his witnesses, and his counsel may have become emotional at times during the trial does not establish that the jurors' damages assessment was infected by passion or prejudice. Rather, after presiding over the trial, listening to the testimony, and observing the jurors, the Court concludes that their desire to punish Defendants and to compensate Dr. Poliner for the loss of his career was a product of reason - not emotion - resulting from a rational deduction that such action was necessary to compensate Dr. Poliner and to effect change in Defendants' conduct in the future.

Dr. Poliner presented himself as a committed and dedicated doctor who was good at and enjoyed his profession. He was respected by his peers and had accumulated an impressive and unblemished career. Defendants came across as arrogant, uncaring, and completely unconcerned with damaging Dr. Poliner's career. The law is obviously written to encourage hospitals and doctors to engage in peer review to correct or eliminate dangerous doctors. However, the law does not encourage callous attempts to find dangerous doctors without concern for doctors' careers and in violation of the hospital's own bylaws and fundamental rules of fairness.

There was nothing in the jurors' behavior to indicate that they were predisposed to Plaintiffs. In light of this conclusion, the Court finds that a remittitur is appropriate.

3. Application of the Maximum Recovery Rule.

Having determined that remittitur is appropriate, the Court must determine whether the Maximum Recovery Rule applies in this case. As stated *supra*, because the facts of each case are different, prior damages awards are not always controlling; the rule does not apply when unique facts or circumstances are present that are not reflected within the controlling caselaw. *See Lebron v. United States*, 279 F.3d 321, 326 (5th Cir. 2002).

Defendants direct the Court's attention to several cases involving medical peer review/suspension of physician staff privileges as well as some defamation cases. Of the cases cited by Defendants, the most analogous is *Rea v. Hosp. Corp. of Am.*, 892 F. Supp. 821 (N.D. Tex. 1993) (Solis, J.). In *Rea*, the court awarded damages for tortious interference with business relations claims involving two physicians' ten-month suspensions of hospital privileges. The court awarded the plaintiffs $197,928.00 in lost earnings damages and $200,000 in punitive damages.

Rea and this case do have some similarities - both cases involved physicians who were initially suspended, but ultimately reinstated. Both cases involved defendant hospitals that failed to follow their own bylaws and failed to give the plaintiffs fair notice and opportunity to be heard. Both cases involved personality clashes between the defendants and the plaintiff physicians. Both cases found that the defendants acted with malice in making their peer review decisions.

Yet this case differs from *Rea* - as well as from the other cases cited by Defendants - in some very key respects. First, this case involves a physician whose career was decimated by Defendants' actions. Dr. Poliner practiced emergency cardiac medicine and relied almost solely on emergency room physician referrals for his business. After being labeled a "dangerous doctor," emergency room doctors stopped referring patients to him, lest they be blamed for sending a patient to an unsafe doctor. Consequently, Dr. Poliner was unable to sustain any kind of practice at Presbyterian. Additionally, because Dr. Poliner did not perform unique services that were in high demand, he was unable to take his expertise to another location. For these reasons, the jury awarded Dr. Poliner a significant amount for damage to career/reputation.

By contrast, in *Rea* the physicians had clinics and privileges at other hospitals in the vicinity and could transfer their work/patients elsewhere in the area. The type of medicine practiced by the physicians in *Rea* was unique and of a non-emergency nature. These doctors had no competition in the area; if a patient wanted the medicine they practiced, the patient went to them. Furthermore, they were not dependent on referrals for their practice. There was no evidence in *Rea* that the defendants' tortious conduct affected the plaintiffs' careers.

Also in *Rea,* the parties agreed to a bench trial whereas in this case there is a jury verdict to consider. Because of the strong presumption in favor of affirming jury awards, the Court will try to give effect to the jury's verdict while keeping in mind that the jury's job was to fairly and reasonably compensate Plaintiffs. *See Bently v. Bunton*, 94 S.W.3d 561, 606 (Tex. 2002).

After reviewing the cases cited by Defendants and after conducting its own research, the Court concludes that the Maximum Recovery Rule does not apply in this case because this case involves unique facts and circumstances that are not reflected within the controlling case law.

4. Calculation of Damages.

Because of the unique facts of this case, the Court must identify the maximum verdict supported by the evidence. *See Smith v. City of Seven Points*, 608 F. Supp. 458, 465 (E.D. Tex.1985). Compensatory and punitive damages will be considered separately. *See id.*

a. *Punitive Damages.*

With regard to punitive damages, Defendants argue that the statutory punitive damages cap established by Section 41.008(b) of the Texas Civil Practices and Remedies Code applies in this case. Plaintiffs respond that they are entitled to an uncapped award of exemplary damages because section 41.008(c)(11) of the Texas Civil Practices and Remedies Code does not limit the amount of punitive damages where a defendant used deception to secure the execution of a document.

Section 41.008(b) states that "exemplary damages awarded against a defendant may not exceed an amount equal to the greater of: (1)(A) two times the amount of economic damages; plus(B) an amount equal to any non economic damages found by the jury, not to exceed $750,000; or (2) $200,000." Tex. Civ. Prac. & Rem. Code § 41.008(b) (Vernon 1997 & Supp. 2005). Section 41.008(c) states that the punitive damages cap does not apply to a cause of action "based on conduct described as a felony in the following sections of the

Penal Code . . . (11) Section 32.46 (securing execution of document by deception)". Tex. Civ. Prac. & Rem. Code Ann. § 41.008(11) (Vernon 1997 & Supp. 2005). At trial, Dr. Knochel testified that he informed Dr. Poliner that Dr. Poliner must agree to a "voluntary" abeyance of his cath lab privileges or Dr. Knochel would terminate all of Dr. Poliner's hospital privileges immediately. Although Dr. Knochel used coercion and duress to convince Dr. Poliner to sign the abeyance letter and acted in violation of the Hospital's bylaws, there was no evidence or finding that he used deception. (*See* Jury Question No. 2.) Thus, Dr. Knochel's conduct could not have constituted a Penal Code violation under Section 32.46. Further, the cause of action for which Plaintiffs seek recovery - defamation - is not a claim based on securing a document by deception. Rather, it is a claim based on the publication of a false statement that harmed Plaintiffs' reputation. For these reasons, the Court concludes that the punitive damages cap applies in this case and therefore, Plaintiffs' punitive damage award is limited to $750,000 plus two times the amount of economic damages against each Defendant.

b. *Actual Damages.*

As noted earlier, nearly all of the actual injury suffered by Plaintiffs falls into a nebulous and intangible category that cannot be precisely calculated. It is difficult to place a price on mental anguish, humiliation and a career/reputation. The evidence presented did cast some light on the degree of injury suffered as a result of Defendants' statements. As stated *supra*, Dr. Poliner's career and reputation were obliterated by Defendants' actions. And Dr. Poliner and his family have endured significant mental anguish. In light of these and other considerations, and after carefully reviewing the trial transcript and the briefing presented, the Court hereby concludes that the maximum possible recovery for Plaintiff's injuries caused by Dr. Knochel's defamatory statements is $6,000,000 for injury to career and reputation and $6,000,000 for mental anguish. Likewise, the Court hereby concludes that the maximum possible recovery for Plaintiff's injuries caused by Presbyterian's defamatory statements is $4,500,000 for injury to career and reputation and $4,500,000 for mental anguish.

MOTION FOR SETTLEMENT CREDIT

Defendants argue in their motion for settlement credit that because Plaintiffs suffered one injury, Defendants are entitled to a settlement credit in the amount of the settlement(s) between Plaintiffs and Drs. Harper and Levin. Defendants cite to the Court's March 26, 2006 Order analyzing the one-satisfaction rule, wherein the Court held that Defendants' unlawful conduct resulted in but one single injury to Plaintiffs. However, as this Order explained herein, the jury was instructed when considering damage amounts to consider each defendant separately and the jury did so with respect to non-economic actual and punitive damages, as indicated by their assessment of different damage amounts against each defendant. Each award represented each defendant's separate contribution to Plaintiffs' single injury, with the single exception of lost earnings. The non-economic and punitive damages awarded against Dr. Knochel and Presbyterian are entirely separate from those amounts awarded against

Drs. Harper and Levin, which have been settled. Therefore, no settlement credit will be given except with respect to economic damages, and Defendants' motion is hereby DENIED in PART.

With respect to economic damages, the Court hereby issues a settlement credit for amounts paid by Drs. Levin and Harper. Rather than hold Dr. Knochel and Presbyterian responsible for the entire $10,526.55 in lost earnings, the Court hereby assesses $5263.28 against Dr. Knochel and $2631.64 against Presbyterian. These amounts were calculated using the four defendants' actual non-economic damages ratio. Drs. Levin and Harper's portion of the economic damages award was paid in their settlement amount.

CONCLUSION

In conclusion, the Court finds that the maximum recovery shown by the evidence in this case against Defendants Dr. Knochel and Presbyterian is $21 million in non-economic actual damages,$7894.92 in lost earnings, and $1,542,106.20 in punitive damages. It is therefore ordered that if Plaintiff agrees to a reduction in actual and punitive damages against Defendants to $22,550,001.12,then Defendants' Motion for New Trial will be DENIED and judgment will be entered in Plaintiffs' favor.

Plaintiffs must indicate acceptance of the remittitur in writing within ten (10) days from the date of this order. If Plaintiffs fail to do so, a new trial limited to the issue of damages will be scheduled.

It is SO ORDERED, this 13th day of October 2006.

/s/
JORGE A. SOLIS
UNITED STATES DISTRICT JUDGE

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

NO. 3:00-CV-1007-P

[Filed October 13, 2006]

LAWRENCE R. POLINER, M.D., and)
LAWRENCE R. POLINER, M.D., P.A.,)
)
Plaintiffs,)
)
v.)
)
TEXAS HEALTH SYSTEMS, A TEXAS)
NON-PROFIT CORPORATION d/b/a)
PRESBYTERIAN HOSPITAL OF DALLAS;)
JAMES KNOCHEL, M.D.; CHARLES)
LEVIN, M.D.; and JOHN HARPER, M.D.,)
)
Defendants.)
)

FINAL JUDGMENT

Pursuant to the Court's Memorandum Opinion and Orders of September 30, 2003, July 7, 2004, March 27, 2006, and October 13, 2006 and the jury verdict returned on August 27, 2004, the Court issues this Final Judgment as follows:

1. Plaintiffs Lawrence R. Poliner, M.D. and Lawrence R. Poliner, M.D., P.A. (collectively, "Plaintiffs") are awarded $22,550,001.12 on

their defamation claim against Defendants Texas Health Systems d/b/a Presbyterian Hospital of Dallas ("Presbyterian Hospital of Dallas") and Dr. James Knochel, M.D. ("Dr. Knochel").

2. Judgment is entered against Dr. Knochel as follows:

    a) $6 million for injury to Dr. Poliner's career;
    b) $6 million for Dr. Poliner's mental anguish;
    c) $5263.28 for economic loss; and
    d) $771,053.10 for punitive damages.

3. Judgment is entered against Presbyterian Hospital of Dallas as follows:

    a) $4.5 million for injury to Dr. Poliner's career;
    b) $4.5 million for Dr. Poliner's mental anguish;
    c) $2631.64 for economic loss; and
    d) $771,053.10 for punitive damages.

4. Plaintiffs take nothing from any Defendants based on Plaintiffs' antitrust claims.

5. Plaintiffs take nothing from any Defendants based on Plaintiffs' Deceptive Trade Practices Act claims.

6. Plaintiffs take nothing from any Defendants based on Dr. Poliner's June 12, 1998 suspension.

7. Plaintiffs take nothing from any of their claims against defendants Charles Harris, M.D., Anthony Das, M.D., David Musselman, M.D., Robert Brockie, M.D., Jorge Cherif, M.D., Steven Meyer, M.D., and Martin Berk, M.D.

8. Costs are assessed against Plaintiffs insofar as those costs were incurred defending those Defendants listed in Paragraph 7.

9. Costs are assessed against Defendants James Knochel, M.D. and Presbyterian Hospital of Dallas insofar as those costs were incurred prosecuting Plaintiffs' claims against said Defendants.

10. Prejudgment interest shall be awarded at the rate of 8.25% beginning from the date suit was filed through the date of judgment.

11. Postjudgment interest shall be awarded at the rate of 4.90% beginning from the day after the date of judgment until the judgment is satisfied.

IT IS SO ORDERED.

Signed this 13th day of October 2006.

/s/

JORGE A. SOLIS
UNITED STATES DISTRICT JUDGE

APPENDIX C

IN THE UNITED STATES DISTRICT FOR THE NORTHERN DISTRICT OF DALLAS DIVISION

CIVIL ACTION NO. 3-00-CV-1007-P

[Filed July 7, 2004]

LAWRENCE R. POLINER, M.D., and)
LAWRENCE R. POLINER, M.D., P.A.,)
)
Plaintiffs,)
)
v.)
)
TEXAS HEALTH SYSTEMS, ET AL.,)
)
Defendants.)
)

ORDER

Now before the Court are Defendants' Request for Findings and Rulings . . . Regarding Scope of Issues to be Tried and Evidence Relevant thereto, filed on March 2, 2004, and Plaintiffs' Cross-Motion for Clarification ("Cross-Motion"), filed March 9, 2004. After careful consideration of the Parties' briefs and the applicable law, the Court GRANTS Defendants' Motion and DENIES Plaintiffs' Cross-Motion.

In their motions, the Parties request clarification of the Court's Memorandum Opinion and Order issued on September 30, 2003 ("Order") regarding the scope of the issues to be tried and the relevant evidence. The Parties disagree as to whether the Court's Order permits Plaintiffs to seek damages flowing from the June 12, 1998 suspension of Dr. Poliner's privileges. Although the Court and the attorneys previously discussed this issue at status conferences held on February 26, 2004, and April 2, 2004, the Court has not yet made a definitive ruling on the issue. Based on the Court's finding that all of the participants in the June 12, 1998 suspension were entitled to immunity, the Court finds that Plaintiffs are not entitled to recover damages flowing from that suspension.

Two separate professional review actions were at issue in this case: (1) the decision to suspend Dr. Poliner's privileges on May 14, 1998, and (2) the IMAC recommendation after review of the AHC's report to suspend Dr. Poliner's privileges on June 12, 1998. *See Mathews v. Lancaster Gen. Hosp.*, 883 F. Supp. 1016, 1028 (E.D. Pa. 1995)(explaining that an initial suspension of a doctor's privileges and a subsequent hearing to review that decision are two separate professional review actions). The Court analyzed each professional review action to determine whether it met the requirements of 42 U.S.C. § 11112(a). In its Order, the Court found that the participants in the June 12, 1998 suspension satisfied the elements of § 11112(a). The Court also determined that Plaintiffs had not produced sufficient evidence to warrant a finding that the participants in the June 12 suspension acted with malice. The Court concluded that the participants in the June 12 suspension were therefore entitled to immunity, and summary judgment was granted in favor of all of the defendants with respect to the June 12 suspension. With respect to the professional review action on May 14, 1998, the Court determined that factual issues existed as to whether the action was a suspension or an abeyance and as to whether Defendants Knochel, Levin, and Harper acted with malice.

The crux of Plaintiffs' argument is that while the Court's Order precludes them from recovering from the participants in the June 12, 1998 suspension, it does not preclude them from recovering from the remaining Defendants based on the decisions made by the participants in the June 12, 1998 suspension. According to Plaintiffs, the Court's Order "did not make any factual findings with respect to the propriety of the peer review proceedings that occurred after the abeyance on May 14, 1998," and "only serves to preclude Plaintiffs' recovery from the Dismissed Defendants based on immunity." (Pls.' Cross-Mot. at 2, 4.) As such, Plaintiffs argue that they should be allowed to pursue damages flowing from the June 12, 1998 suspension.

To support their arguments, Plaintiffs point to the fact that the Court cannot make any fact findings in a summary judgment proceeding. The Court agrees with Plaintiffs that the Court's Order did not make any findings of fact. However, the Order determined, in accordance with Federal Rule of Civil Procedure 56, that no issue of material fact existed with respect to the June 12, 1998 suspension to warrant submission to a jury. Plaintiffs' attempt to inject the propriety of the

June 12, 1998 suspension before the jury is simply an attempt to circumvent the Court's Order.

Because the Court has determined that the June 12, 1998 suspension was carried out in accordance with federal and state statutes, those statutes prohibit the recovery of any damages resulting from that suspension. Allowing Plaintiffs to recover damages for the June 12, 1998 suspension would allow Plaintiffs to recover damages without showing that the suspension violated the Health Care Quality Improvement Act and without showing that the June 12, 1998 suspension was carried out with malice. This is contrary to the language and purposes of the immunity statutes, and therefore, the Court finds that Plaintiffs are not entitled to recover damages flowing from Dr. Poliner's June 12, 1998 suspension.

In light of this ruling, the propriety of the AHC's review and the IMAC's recommendation is no longer at issue. Accordingly, evidence of malice or the motive of any of the participants in the June 12, 1998 suspension is not relevant, nor is any evidence regarding the AHC's analysis of the patients' files examined.

For the reasons set forth above, the Court GRANTS Defendants' motion for clarification regarding the scope of the issues to be tried and DENIES Plaintiffs' Cross-Motion.

IT IS SO ORDERED.

Signed this 7th day of July 2004.

/s/

JORGE A. SOLIS
UNITED STATES DISTRICT JUDGE

APPENDIX D

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF TEXAS DALLAS DIVISION

No. 3:00-CV-1007-P

[Filed September 30, 2003]

LAWRENCE R. POLINER, M.D., Plaintiff,	)
v.	)
TEXAS HEALTH SYSTEMS, A TEXAS NON-PROFIT CORPORATION D/B/A PRESBYTERIAN HOSPITAL OF DALLAS; JAMES KNOCHEL, M.D.; CHARLES HARRIS, M.D.; ANTHONY DAS, M.D.; CHARLES LEVIN, M.D.; DAVID MUSSELMAN, M.D.; JOHN HARPER, M.D.; ROBERT BROCKIE, M.D.; JORGE CHERIF, M.D.; STEVEN MEYER, M.D.; AND MARTIN BERK, M.D., Defendants.	)

MEMORANDUM OPINION AND ORDER

Now before the Court are the following:

1. Defendants' Motion for Summary Judgment, with brief in support and appendix, filed May 15, 2002;

2. Plaintiff's Response to Defendants' Motion for Summary Judgment, with brief in support and appendix, filed June 11, 2002;

3. Defendants' Reply to Plaintiff's Response to Defendants' Motion for Summary Judgment and Brief in Support, filed June 26, 2002;

4. Defendants' Objections to Plaintiff's Summary Judgment Evidence, filed June 26, 2002 and December 5, 2002;

5. Plaintiff's Motion for Leave to Supplement Response to Defendants' Motion for Summary Judgment and to Take Additional Depositions and Brief in Support, filed June 11, 2002;

6. Defendants' Response to Plaintiff's Motion for Leave to Supplement Response to Defendants' Motion for Summary Judgment and to Take Additional Depositions, Motion to Strike, Motion for Protective Order and Brief in Support, filed June 18, 2002;

7. Defendants' Response to Plaintiff's Motion for Leave to Supplement Response to Defendants' Motion for Summary Judgment and to Take Additional Depositions, Motion

to Strike, Motion for Protective Order and Brief in Support, filed June 19, 2002;[1]

8. Plaintiff's Reply to Defendants' Response to Motion for Leave to Supplement Response to Defendants' Motion for Summary Judgment and to Take Additional Depositions and Brief in Support, with appendix, filed July 3, 2002;

9. Plaintiff's Response to Defendants' Motion to Strike and for Protective Order and Brief in Support, filed July 8, 2002;

10. Defendants' Motion to Limit the Number of Experts Designated on the Same or Similar Topic and Brief in Support, filed June 17, 2002;

11. Plaintiff's Response to Defendants' Motion to Limit the Number of Experts Designated on the Same or Similar Topic, and Brief in Support, filed June 28, 2002;

12. Defendants' Motion to Quash and for Protective Order Regarding Plaintiff's Notice of Intention to Take Oral Deposition of Dr. Morton Kern and Brief in Support Thereof, filed June 19, 2002;

---

[1] The Court notes that Defendants' Response and Motion to Strike and for Protective Order is a duplicate of Defendants' previous filing on June 18, 2002, listed above as item number 6. As such, the Court DENIES this motion as MOOT.

13. Plaintiff's Response to Defendants' Motion to Quash and for Protective Order Regarding Plaintiff's Notice of Intention to Take Oral Deposition of Dr. Morton Kern and Brief in Support, filed June 28, 2002;

14. Defendants' Reply to Plaintiff's Response to Defendants' Motion to Limit the Number of Experts Designated on the Same or Similar Topic and Defendants' Reply to Plaintiff's Response to Defendants' Motion to Quash and for Protective Order and Brief in Support, filed July 2, 2002.

15. Plaintiff's Supplemental Response to Defendants' Motion for Summary Judgment filed on November 20, 2002;

16. Defendants' reply to Supplemental Response filed on December 5, 2002, and;

17. Plaintiff's Motion to Amend Complaint filed on July 11, 2002;

18. Defendants' response to plaintiff's Motion to Amend Complaint filed on July 31, 2002;

19. Plaintiff's reply to defendant's response to plaintiff's Motion to Amend Complaint filed on August 15, 2002.

After a thorough review of the evidence, the pleadings, the parties' briefs, and the applicable law, for the reasons set forth below, the Court is of the opinion that (1) Defendant's Motion for Summary

Judgment should be GRANTED in part, and DENIED in part; (2) Defendants' Objections to Plaintiff's Summary Judgment Evidence (Docket entries nos. 171 and 232) should be DENIED as MOOT, except where noted otherwise; (3) Plaintiff's Motion for Leave to Supplement Response and to Take Additional Depositions (Docket entry no. 147) should be DENIED; (4) Defendants' Motion to Strike and for Protective Order (Docket entries nos. 164 and 166) should be DENIED; (5) Defendants' Motion to Limit the Number of Experts Designated on the Same or Similar Topic (Docket entry no. 163) should be DENIED; (6) Defendants' Motion to Quash and for Protective Order Regarding Dr. Morton Kern (Docket entry no. 165) should be DENIED as MOOT; and (7) Plaintiff's Motion to Amend Complaint (Docket entry no. 198) is GRANTED.

INTRODUCTION

Plaintiff Lawrence R. Poliner, M.D., ("Dr. Poliner") filed this suit before the Court against Texas Health Systems d/b/a Presbyterian Hospital of Dallas (hereinafter "Hospital" or "PHD"), and Doctors James Knochel, Charles Harris, Anthony Das, Charles Levin, David Musselman, John Harper, Robert Brockie, Jorge Cherif, Steven Meyer, and Martin Berk (collectively "Defendants"), for claims arising out of a peer review which resulted in a suspension of Plaintiff's cardiac cath lab and echocardiography privileges at the Hospital for part of 1998. Specifically, Dr. Poliner alleges that the Defendants, by participating in the suspension of his privileges: (1) entered into a combination and conspiracy in violation of Sections 1 and 2 of the Sherman Act and Section 4 of the Clayton

Act (all Defendants); (2) engaged in an unlawful combination and conspiracy in violation of the Texas Free Enterprise and Anti-Trust Act of 1983 (all Defendants); (3) breached his contractual due process rights created under the Hospital's Bylaws (Hospital only); (4) caused business disparagement, slander and libel (all Defendants); (5) caused tortious interference with business (all Defendants); (6) caused tortious interference with prospective advantage (all Defendants); (7) violated the Deceptive Trade Practices Act (all Defendants); and (8) caused intentional infliction of mental anguish and emotional distress (all Defendants). *See generally* Third Am. Compl. In his remaining counts, Plaintiff's other requested relief includes: (9) an application for temporary restraining order, temporary injunction and permanent injunction (Hospital only); (10) a request for declaratory relief that Defendants' actions are not entitled to immunity under either the Health Care Quality Improvement Act ("HCQIA") or the Texas Medical Practice Act (all Defendants); and (11) a request for declaratory relief that the HCQIA and the Texas Medical Practice Act are unconstitutional as enacted. *See* Id.

Meanwhile, Defendants have moved for summary judgment on each count on the grounds that: (a) Texas law does not recognize a cause of action for suspension of hospital privileges; (b) neither the Texas Medical Practice Act, nor HCQIA creates a private cause of action for temporary suspension of hospital privileges; (c) the HCQIA and the Texas Peer Review statutes immunize the peer review activity of Defendants from liability; (d) Plaintiff's antitrust allegations, even if taken as true, (i) preclude a finding of an unreasonable restraint of trade within the ambit of the antitrust laws, (ii) are barred by the intraenterprise immunity doctrine, (iii) there is no effect on interstate commerce as a matter of law, and (iv) Presbyterian does not possess the requisite market power within the relevant market to give rise to liability; (e) there is no evidence of any contract between Plaintiff and Defendants; (f) Plaintiff can produce no evidence of any prospective contracts between Plaintiff and third parties that were affected by the alleged interference; (g) Plaintiff's business disparagement, slander and libel claims are barred by the one-year statute of limitations and are based on statements protected by privilege; (h) Defendants are entitled to summary judgment on Plaintiff's claims for intentional infliction of mental anguish and emotional distress; (i) Defendants are entitled to summary judgment on Plaintiff's claims for alleged violation of Texas Deceptive Trade Practices Act; (j) Plaintiff's request for injunctive relief fails as a matter of law due to the existence of an adequate remedy at law; and (k) Plaintiff's request for declaratory judgment fails to plead a complaint that is remediable by declaratory judgment, and it merely encompasses previously pleaded claims in order to create a basis for an award of attorney's fees. *See generally* Defs.' Mot. Summ. J. at 3-4. Each of these arguments will be considered in turn.

BACKGROUND

Dr. Poliner received his medical degree from Cornell University School of Medicine in 1969, and completed his residency in Internal Medicine at the University of Colorado in 1972. He became board certified in internal medicine in 1972 and in cardiovascular diseases in 1977. Dr. Poliner first applied for privileges at PHD in May 1996. He was granted temporary privileges in June 1996, and formally appointed to the hospital staff in January 1997. The first year of Dr. Poliner's appointment to the medical staff at PHD was provisional, and in July 1997, Dr. Poliner applied for reappointment to the medical staff. He was granted reappointment at PHD in October 1997.

On September 29, 1997, a nurse in the Cardiac Catheterization Lab ("Cath Lab") filled out a Committee Event Report Form ("CERF") on Dr. Poliner with respect to patient no. 18. This patient died following a procedure on the patient by Dr. Poliner in the cath lab. The CERF was referred to the hospital's Clinical Risk Review Committee ("CRRC"). On October 29, 1997, another nurse in the cath lab filed a CERF on Dr. Poliner with respect to patient no. 9. Patient no. 9 suffered a stroke following a cath lab procedure by Dr. Poliner. The nurse's report indicated a concern that the patient developed chest pain and signs of a stroke after the cath lab procedure. Although he was informed of the patient's symptoms, Dr. Poliner did not go to see the patient until the following day. This report was also referred to the CRRC. On December 18, 1997, a nurse in the cath lab filled out a CERF on Dr. Poliner with respect to patient no. 3. The CERF concerned Dr. Poliner's alleged use of a contaminated sheath and was also referred to the CRRC. On January 12, 1998, the CRRC took up discussion of the referrals concerning patients nos. 3 and 18. Among the functions of the CRRC is to refer identified issues of patient care concerns to the appropriate department or committee. Following review of the cases involving patients nos. 3 and 18, the CRRC decided to refer both cases to the hospital's Internal Medicine Department for further review. The issues the CRRC identified with respect to patient no. 18 included whether the patient met the criteria for the procedure performed by Dr. Poliner, "evaluation of the cardiologist's procedural technique", and "evaluation of practitioner trends particularly with complications during interventional cardiac procedures." In the Internal Medicine Department, review of the cases was assigned to the Internal Medicine Advisory Committee ("IMAC"). IMAC was a PHD committee with responsibility for reviewing cases where quality of patient care concerns were raised involving doctors in the Internal Medicine Department. Cardiology was part of the Internal Medicine Department at PHD. The CERF report concerning patient no. 9 was taken up by the CRRC on April 13, 1998, and the CRRC subsequently decided to refer that case to the IMAC for further review. Issues identified by the CRRC with respect to patient no. 9 again included "evaluation of practitioner trends particularly complications with or following interventional cardiac procedures" and "evaluation of the overall medical management of the patient." IMAC review of the cases involving patients nos. 3, 9, and 18 was still pending when a case involving patient no. 36 was brought to the attention of Dr. John Harper by Dr. Charles Levin on May 13, 1998. Dr. Levin was director of the cath lab on May 12, 1998, and part of his duties involved occasional review of emergency cases. Dr. Poliner had performed an emergency angioplasty on patient no. 36 on May 12, and Dr. Levin reviewed the film of the procedure. Upon review of the film, Dr. Levin concluded that Dr. Poliner performed the angioplasty on the wrong artery and missed a totally occluded left anterior descending coronary artery. Dr. Levin considered this error potentially life threatening to the patient. Dr. Levin informed Dr. Harper, then Chief of Cardiology, on May 13, 1998 of his findings with respect to patient no. 36. Dr. Knochel, Chairman of the Department of Internal Medicine, was also informed about patient no. 36 on May 13, 1998. Dr. Knochel testified that in addition to the missed occluded artery, he had also received complaints from nurses who were concerned that Dr. Poliner had not paid adequate attention to the needs of patient no. 36 once the patient had been transferred to the floor from the cath lab. In light of the events concerning patient no. 36 and the other reports concerning Dr. Poliner which were then under review, Dr. Knochel spoke to Mark Merrill, President of PHD, Bruce Bougeno, Vice-President of Medical Staff Affairs, and George Pearson, in-house counsel for PHD. Dr. Knochel asked plaintiff to accept abeyance of all procedures in the cath lab until an ad hoc committee appointed by Knochel could review plaintiff's cath lab cases. Drs. Levin and Harper were present at the meeting between Knochel and plaintiff. According to plaintiff, he was given an abeyance letter after 2:00 p.m. on May 14, 1998 and told to sign and return it by 5:00 p.m. that day or his privileges would be immediately suspended. Plaintiff alleges he was not told about patient no. 36, was not given an opportunity to defend himself against the accusations, and was not told which of his patients were going to be reviewed by the ad hoc committee. Plaintiff was told not to consult an attorney before deciding whether to sign the abeyance letter. Plaintiff signed and returned the abeyance letter agreeing to an abeyance. The abeyance of plaintiff's cath lab privileges did not extend to plaintiff's admission and consultation privileges at the hospital. Dr. Knochel then appointed six doctors, all cardiologists at PHD, to the ad hoc committee ("AHC"): Dr. Robert Brockie, Dr. Jorge Cheirif, Dr. Anthony Das, Dr. Charles Harris, Dr. Steven Meyer, and Dr. William Reardon. All members of the ACH except Dr. Reardon are named defendants in this suit. The AHC met on May 20, 1998 and reviewed forty-four (44) of plaintiff's cases. All but two of the cases reviewed by the AHC were selected by the medical staff office at PHD or selected at random. Two of the cases selected for review by the AHC were selected because of concerns which had been raised regarding those patients. After reviewing the cases, the AHC concluded that substandard care was rendered in twenty-nine (29) of the cases. The IMAC then met on May 27, 1998 to consider the report of the AHC. The members of the IMAC were Dr. David Musselman, Dr. Steven Rinner, Dr. Lyle Kaliser, and Dr. William Harvey with Dr. Knochel serving as chairman. Dr. Musselman was the only cardiologist on the committee, and is the only member of the IMAC named by Dr. Poliner as a defendant in this case. The IMAC recommended that additional reviews of echocardiograms be performed and that an outside reviewer be asked to review the cases. The IMAC further recommended extending the abeyance for two weeks to allow time for the echocadiogram reviews and for the outside review. By letter of May 29, 1998, plaintiff was asked, and he agreed, to extend the abeyance until June 12, 1998. Defendants assert that an outside reviewer could not be found who could perform the necessary reviews in time for the hearing. On June 8, 1998, Dr. Knochel sent plaintiff a letter advising him of an IMAC meeting on June 11, 1998 as part of the peer review process. The meeting was scheduled from 8:00 a.m. to 9:00 a.m. Plaintiff was provided a list of patients whose cases had been reviewed and informed that the records pertaining to those cases would be made available for plaintiff's review. On June 10, 1998, plaintiff sent Dr. Knochel a letter requesting a postponement of the IMAC hearing until June 12 or until the afternoon of June 11. Dr. Poliner stated he needed more time to review all of the material necessary. By letter of June 10, 1998, Dr. Knochel refused Dr. Poliner's request for a delay. The IMAC meeting proceeded as scheduled, and Dr. Poliner was given one hour to present his response to the concerns raised about his patient care. On June 12, 1998, the IMAC voted unanimously to recommend suspension of Dr. Poliner's privileges and identified the following specific concerns: (1) poor clinical judgment; (2) inadequate skills, including angiocardiography and echocardiography; (3) unsatisfactory documentation of medical records; and (4) substandard patient care. After obtaining the recommendations of the IMAC, Dr. Knochel summarily suspended Dr. Poliner's cath lab and echocardiography privileges and informed Dr. Poliner of his decision by letter dated June 12, 1998. Dr. Knochel's letter further advised Dr. Poliner that the suspension did not extend to admission and consultation privileges or to any privilege not performed in the Cardiac Cath Lab or echocardiograms at PHD. Dr. Poliner was also advised that he was entitled to an expedited hearing concerning his suspension in accordance with PHD's Medical Staff By-Laws. On July 10, 1998, Dr. Poliner wrote Mark Merrill, President of PHD, and requested a hearing concerning the suspension of his privileges. The letter did not request an expedited hearing. Mr. Merrill informed Dr. Poliner by letter of August 14, 1998, that a hearing before a Hearing Committee of PHD's Medical Staff was scheduled for September 14, 1998 at 6:00 p.m. The letter also identified the five members of the Hearing Committee. On August 19, 1998, plaintiff's counsel requested a continuance of the hearing due to a scheduling conflict of his co-counsel. By letter of October 5, 1998, Mr. Merrill informed Dr. Poliner that the hearing was continued until November 3, 1998 at 6:00 p.m. and on November 4, 1998. Dr. Poliner objected generally that the Hearing Committee did not include any cardiologists but did not object to any of the individual members of the committee. Dr. Poliner also acknowledges that he was not in direct competition with any of the members of the Hearing Committee. A hearing was held on November 3, 4, and 5, 1998. On November 9, 1998, the Hearing Committee issued its report. The Hearing Committee recommended unanimously that Dr. Poliner's privileges should be restored with conditions, and found unanimously that the summary suspension of Dr. Poliner's privileges was justified based on the evidence available at the time. On November 18, 1998, the hospital's Medical Board met and accepted the recommendation of the Hearing Committee. Dr. Poliner was informed of the Medical Board's decision by letter of November 20, 1998. By letter of January 15, 1999, Dr. Poliner advised Mr. Merrill that he wished to appeal to the hospital's Committee on Professional Affairs ("COPA") the summary suspension of his privileges on June 12, 1998. Dr. Poliner expressed concern that, although his privileges had been restored, the presence of the summary suspension on his record would continue to be harmful to him. Dr. Poliner was advised that, pursuant to the hospital's bylaws, his appeal was limited to a determination of whether Dr. Poliner had been substantially provided with the procedural due process provided in the bylaws. COPA met on March 2, 1999 to consider Dr. Poliner's appeal. COPA ultimately found that Dr. Poliner had been afforded procedural due process during the peer review process and that it did not have the authority to set aside the summary suspension of privileges. On June 7, 1999, the hospital's Board of Trustees upheld the decision of COPA. None of the individual defendants in this suit were on the hearing committee or COPA. Plaintiff then filed this suit on May 11, 2000.

DISCUSSION

I. Summary Judgment Standard

Summary judgment shall be rendered when the pleadings, depositions, answers to interrogatories and admissions on file, together with affidavits, if any, show that there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c); *Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986). All evidence and the reasonable inferences to be drawn therefrom must be viewed in the light most favorable to the party opposing the motion. *United States v. Diebold, Inc.*, 369 U.S. 654, 655 (1962).

The moving party bears the burden of informing the district court of the basis for its belief that there is an absence of a genuine issue for trial, and of identifying those portions of the record that demonstrate such an absence. *Celotex*, 477 U.S. at 323. Once the moving party has made an initial showing, the party opposing the motion must come forward with competent summary judgment evidence of the existence of a genuine fact issue. *Matsushita Elec. Indus. Co., Ltd. v. Zenith Radio Corp.*, 475 U.S. 574, 586 (1986). The party defending against the motion for summary judgment cannot defeat the motion unless he provides specific facts that show the case presents a genuine issue of material fact, such that a reasonable jury might return a verdict in his favor. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). Mere assertions of a factual dispute unsupported by probative evidence will not prevent summary judgment. *Id.* at 248-50; *Abbot v. Equity Group, Inc.*, 2 F.3d 613, 619 (5th Cir. 1993). In other words, conclusory statements, speculation and unsubstantiated assertions will not suffice to defeat a motion for summary judgment. *Douglass v. United Servs. Auto. Ass'n*, 79 F.3d 1415, 1429 (5th Cir. 1996) (en banc). If the nonmoving party fails to make a showing sufficient to establish the existence of an element essential to its case, and on which he bears the burden of proof at trial, summary judgment must be granted. *Celotex*, 477 US. at 322-23. The Court will not, in the absence of any proof, assume that the nonmoving party could or would prove the essential facts necessary to support a judgment in favor of the nonmovant. *See Little v. Liquid Air Corp.*, 37 F.3d 1069, 1075-1076 (5th Cir. 1994).

Finally, the Court has no duty to search the record for triable issues. *Ragas v. Tennessee Gas Pipeline Co.*, 136 F.3d 455, 458 (5th Cir. 1998). "The party opposing summary judgment is required to identify specific evidence in the record and to articulate the precise manner in which the evidence supports his or her claim." *Id.* A party may not rely upon "unsubstantiated assertions" as competent summary judgment evidence. *Id.*

II. The Antitrust Claim

Dr. Poliner alleges that by participating in the suspension of his privileges the Defendants: (1) entered into a combination and conspiracy in violation of Sections 1 and 2 of the Sherman Act and Section 4 of the Clayton Act; and (2) engaged in an unlawful combination and conspiracy in violation of the Texas Free Enterprise and Anti-Trust Act of 1983. The same elements are required to establish a violation of the Texas Free Enterprise and Anti-Trust Act and the comparable sections of the Sherman Act. Further the Texas statute is to be read in harmony with the Sherman Act. Thus, the Court will examine these claims together. *See Nafrawi v. Hendrick Med. Ctr.*, 676 F. Supp. 770, 774 (N.D. Tex. 1987) (citing Tex. Bus. & Com. Code Ann. § 15.05(a) (Vernon 1997)).

The Fifth Circuit has previously observed that the Sherman Act "does not purport to afford remedies for all torts committed by or against persons engaged in interstate commerce." *Kiepfer, M.D. v. Beller*, 944 F.2d 1213, 1221 (5th Cir. 1991) (citing *Larry R. George Sales Co. v. Cool Attic Corp.*, 587 F.2d 266, 272 (5th Cir. 1979). "The limited scope of the antitrust laws results from the fact that they are intended to protect *competition*, not necessarily *competitors*." *Id.* Thus, as an initial matter, an antitrust plaintiff must show not just that the defendants' actions injured him, but that they unreasonably restrained competition. *Id.* ("[f]ederal courts have consistently held that Section 1 of the Sherman Act prohibits only unreasonable restraint of trade; in the ordinary case, alleged violations are judged by a 'rule of reason'").

Section 1 of the Sherman Antitrust Act forbids contracts, combinations, or conspiracies in restraint of trade or commerce. 15 U.S.C. § 1. To prevail on a section 1 claim, plaintiff must show that the defendants (1) engaged in a conspiracy, (2) that produced some anti-competitive effect, (3) in the relevant market. *Johnson, D.O. v. Hosp. Corp. of Am.*, 95 F.3d 383, 392 (5th Cir. 1996). Section 1 applies only to concerted action; unilateral conduct is excluded from its purview. *Id.*

The Court finds that Plaintiff has failed to establish that the suspension of his privileges was the result of anti-competitive concerted action on the part of the Defendants. Courts have cautioned that "[i]f the claim is one that simply makes no economic sense, respondents must come forward with more persuasive evidence to support their claim than otherwise would be necessary." *Johnson*, 95 F.3d at 393. Plaintiff contends that the AHC was made up of his competitors. Plaintiff asserts that over seventy percent of all cardiology procedures at PHD were performed by two groups, the North Texas Heart Center ("NTHC") and the Cardiology and Internal Medicine Association ("CIMA"). Plaintiff maintains that these two groups made up the AHC and wanted to eliminate plaintiff as a competitor. However, three of the six doctors on the AHC were not members of either NTHC or CIMA. These three doctors were independent doctors as was plaintiff. Apart from his general assertions, plaintiff has not presented any evidence of concerted anti-competitive action by the cardiologists at PHD.

Further plaintiff offers no explanation as to why the independent doctors on the AHC had any motive to eliminate plaintiff as a competitor. These doctors were in the same circumstances as plaintiff in that they were competing with the two large groups at PHD. Nor does plaintiff offer any explanation for why the two large cardiology groups did not turn their anti-competitive designs on these other independent doctors. The Court finds that there is no evidence that any of the individual doctor Defendants stood to benefit economically from the suspension of Plaintiff's privileges here. *See Rea, M.D. v. Hosp. Corp. of Am.*, 892 F. Supp. 821, 825 (N.D. Tex. 1993). Monitoring the competence of physicians through peer review is clearly in the public interest, and revocation or suspension of a physician's privileges because of legitimate concerns about the quality of patient care that he rendered is obviously a lawful objective. *Willman, M.D. v. Heartland Hosp. East*, 34 F.3d 605, 610 (8th Cir. 1994). Thus, plaintiff has not shown any anti-competitive conspiracy.

Nevertheless, even assuming the established proof of a conspiracy to suspend his privileges plaintiff must still show harm to competition sufficient to demonstrate a Section 1 violation because of the suspension of his cardiac cath lab and echocardiography privileges at the Hospital for part of 1998. *See Doctor's Hosp. of Jefferson, Inc. v. Southeast Med. Alliance, Inc.*, 123 F.3d 301 (5th Cir. 1997). To prove a Section 1 violation, plaintiff must show that defendants' activities caused an injury to competition. *Id.* at 307.

Dr. Poliner has not presented evidence that affiliation with the NTHC or CIMA was necessary to compete in the marketplace or that the suspension of his privileges somehow reflected injury to competition generally. Although the Court assumes for present purposes that Plaintiff was damaged as a result of his suspension and that Defendants intended to harm Dr. Poliner by suspending his privileges, Plaintiff cannot show that it rendered him unable to compete. At the time of his suspension, Plaintiff continued to have privileges at other hospitals in the area. The summary judgment evidence shows that plaintiff had full staff privileges at five other hospitals and courtesy privileges at two other hospitals at the time of his summary suspension. (Plf. App., Vol. 4, at 2428-29). Further, the number of providers available to the ultimate consumers was not reduced. Thus, the ability of purchasers to choose health care providers was unchanged as Dr. Poliner's services remained available to consumers at other health care facilities. Therefore, in the absence of any anticompetitive effect in any market, the Court holds that a jury could not properly find that Defendants' actions violated Section 1 of the Sherman Act.

Section 2 of the Sherman Act prohibits the monopolization or attempted monopolization of any part of interstate trade or commerce. 15 U.S.C. § 2. To prove monopolization, the plaintiff must demonstrate that the defendant had both the capacity and the intent to monopolize. *Seidenstein, M.D. v. Nat'l Medical Enter., Inc.*, 769 F. 2d 1100, 1105-1106 (5th Cir. 1985). In addition, to establish Section 2 violations premised on attempt and conspiracy to monopolize, a plaintiff must define the relevant market. *Doctor's*

Hosp. of Jefferson, 123 F.3d at 311. "To define a market is to identify producers that provide customers of a defendant firm (or firms) with alternative sources for the defendant's product or services." *Id.* The relevant product and geographic markets must reflect the realities of competition. *Id.*

Defendants here urge that the relevant market urged by Dr. Poliner and his experts is too narrowly drawn as it consists only of Defendant Hospital. The Court agrees. Notably, "every court that has addressed this issue has held or suggested that, absent an allegation that the hospital is the only one serving a particular area or offers a unique set of services, a physician may not limit the relevant geographic market to a single hospital." *Ginzberg, M.D. v. Memorial Healthcare Systems, Inc.*, 993 F. Supp. 998, 1013 (S.D. Tex. 1997). Defendants' expert opines that the relevant market is a seventeen county area around Dallas-Ft. Worth from which PHD attracted its cardiology patients. The court notes that all but two of the seventeen counties from which PHD drew its cardiology patients are north of Dallas. One county, Kaufman, is east and slightly southeast of Dallas, and the other, Henderson is southeast. (Def. App., Vol. 2, at 1065, 1076). Thus, an argument could be made that the realty of competition is that PHD draws its patients from Dallas County and areas to the north of Dallas County. The court finds that the relevant product market is, at least, the provision of inpatient invasive cardiology procedures. The relevant market is at least the City of Dallas north of Interstate 30, or north of downtown.

As noted above, Dr. Poliner had privileges at other hospitals after his privileges were suspended at PHD.[2] Plaintiff's summary judgment evidence establishes that he was able to treat some of his patients at other hospitals following his suspension at PHD. In establishing a Section 2 violation, plaintiff must present evidence concerning where the ultimate consumers of the relevant medical services could go for alternative services. *Doctor's Hospital of Jefferson v. Southeast Medical Alliance Inc.*, 123 F.3d at 311. Plaintiff has failed to produce any evidence that ultimate consumers of the relevant medical services could not turn to hospitals other than PHD to obtain the services. To the contrary, the evidence shows that consumers could and did utilize other hospitals after plaintiff lost his privileges at PHD. Although plaintiff's expert presents evidence that the two primary cardiology groups at PHD increased their share of business following plaintiff's suspension of privileges, plaintiff offers no evidence that PHD or the defendant doctors increased their business in the larger relevant market. Thus, because plaintiff's proposed relevant market is too narrow, evidence of what happened at PHD following plaintiff's suspension is not sufficient to establish that defendants had market power in the relevant market. That is, plaintiff has not shown that defendants had the ability or opportunity to dominate or to attempt to monopolize the larger relevant market outside PHD. *Id.* Therefore, plaintiff has failed to establish that a fact issue exists with respect to his Sherman Act, Section 2 claim.

---

[2] The summary judgment evidence shows that PHD was the second largest provider of cardiology services in the Dallas-Ft. Worth area. (Def. App., Vol. 2 at 1067). Besides PHD, plaintiff had privileges at the third and eighth largest providers of cardiology services in the same area. (Plf. App., Vol. 4, at 2428-29).

Defendants' motion for summary judgment is granted with respect to all of plaintiff's antitrust claims.

III. Procedural Rights Under the Medical Bylaws

Under Texas law, an important distinction exists between (a) medical bylaws, which are bylaws created by the medical staff to control the governance of the medical professionals with privileges at the hospital, and (b) hospital bylaws, which are a set of bylaws created by the hospital itself and adopted by its governing board. *See Gonzalez v. San Jacinto Methodist Hosp.*, 880 S.W.2d 436, 438 (Tex. Civ. App.- Texarkana 1994, writ denied). Under the former, it is generally understood that rights promulgated by *medical staff bylaws* are considered incapable of creating an enforceable contract between the hospital and its physicians. *See Weary v. Baylor Univ. Hosp.*, 360 S.W.2d 895, 897-898 (Tex. Civ. App.- Waco 1962, writ ref'd n.r.e.); *see also Stephen, M.D. v. Baylor Medical Ctr. at Garland*, 20 S.W.3d 880, 887 (Tex. Civ. App.- Dallas 2000, no writ). However, under the latter, procedural rights prescribed under *hospital bylaws* may constitute contractual rights between the physicians and the adopting hospital. *See Gonzalez*, 880 S.W.2d at 438-39; *see also Stephen*, 20 S.W.3d at 887. Federal courts applying Texas law have adhered to this view. *See Monroe v. AMI Hosp. of Tex., Inc.*, 877 F. Supp. 1022, 1029 n.5 (S.D. Tex. 1994) ("This court notes, however, under Texas law, a hospital's medical staff bylaws do not constitute a contract between a hospital and its medical staff members").

PHD's bylaws provide that the "Medical/Dental Staffs' Bylaws shall provide a process for denying, withdrawing or qualifying staff privileges, which provides procedural due process for the member." PHD's Bylaws, Art. Eleven, § 11.04. In turn, the medical staffs' bylaws provide that summary suspension of privileges can be made when the conduct of the physician "constitutes a present danger to the health of his patients." Medical Staffs' Bylaws, Art. VIII - Part C: Section 2(a). PHD argues that because the Board of Trustees of the hospital retain the final authority with respect to suspensions, the medical staffs' bylaws do not create contractual rights for members of the staff. The court disagrees. The court finds that the hospital bylaws in this case are similar to the bylaws in *Gonzalez v. Sun Jacinto Methodist Hospital*, 880 S.W.2d 436 (Tex.-Texarkana 1994). In *Gonzalez*, the hospital bylaws provided that when a staff member's privileges were to be suspended or terminated the member was entitled to a hearing before the Medical Staff. The bylaws further provided that the hearing "shall be conducted formally under procedures adopted by the Board of Directors and contained in the Medical Staff Bylaws, Rules and Regulations to assure due process and afford full opportunity for the presentation of all pertinent information." In the present case, the hospital bylaws directed that the process for suspension of members' privileges was to by provided by the Medical Staffs' bylaws and were to provide for procedural due process for the member. As in *Gonzalez*, the bylaws of the PHD medical staff were subject to approval of the Board of

Trustees of PHD and were to provide procedural due process for the staff members. PHD Bylaws, Art. Eleven, §§ 11.02 & 11.04. Thus, the court finds that the hospital bylaws in the present case provided contractual procedural due process rights. As discussed below, the court has determined that there are fact issues as to whether defendant PHD breached its contractual obligations to insure procedural due process for plaintiff. Hence, PHD's motion for summary judgment is denied with respect to plaintiff's breach of contract claim.

IV. State Law Claims

As described above, Dr. Polinar brings several state law claims against all of the defendants. The defendants assert they are entitled to summary judgment on all of plaintiff's state law claims based upon immunity under the Healthcare Quality Improvement Act ("HCQIA"), 42 U.S.C. § 11111 *et seq.*, and the Texas Peer Review Immunity Statutes, Tex. Occ. Code Ann. § 160.001 *et seq.* These arguments will be addressed below.

A. The Healthcare Quality Improvement Act

The HCQIA was enacted to provide for effective peer review and interstate monitoring of incompetent physicians, and also to provide qualified immunity for peer review participants. *Austin v. McNamara, M.D.*, 979 F.2d 728, 733 (9th Cir. 1992). In furtherance of the latter goal, the HCQIA states that if a "professional review action[3] of a professional review body[4] meets certain [specified] standards, then (A) the professional review body, (B) any person acting as a member or staff to the body, (C) any person under contract or other formal agreement with the body, and (D) any person who participates with or assists the body with respect to the action, shall not be liable in damages under any law of the United States or any State . . . with respect to the action." *See* 42 U.S.C. § 11111(a) (2001).

In order for immunity to apply under the HCQIA, the professional review action must be taken:

> (1) in the reasonable belief that the action was in furtherance of quality health care,
>
> (2) after a reasonable effort to obtain the facts of the matter,

---

[3] A "professional review action" means "an action or recommendation of a professional body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician. *See* 42 U.S.C. § 11151(9).

[4] A "professional review body" means "an activity of a health care entity with respect to an individual physician -

> (A) to determine whether the physician may have clinical privilege with respect to, or membership in, the entity;
> (B) to determine the scope or condition of such privileges or membership; or
> (C) to change or modify such privileges or membership.

See 42 U.S.C. § 11151(10).

> (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
>
> (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3) [above].

See 42 U.S.C. § 11112(a). The Act also includes a presumption that a professional review action meets each of the four prongs of Section 11112(a), unless the plaintiff can rebut the presumption by a preponderance of the evidence. *See* Id.; *see also Brader v. Allegheny Gen. Hosp.,* 167 F.3d 832, 839 (3rd Cir. 1999).

The standard for reviewing summary judgment under the HCQIA is therefore unconventional: although the defendant is the moving party, the court must examine the record to determine whether the plaintiff has "satisfied his burden of producing evidence that would allow a reasonable jury to conclude that the peer disciplinary process failed to meet the standards of HCQIA." *Brader*, 167 F.3d at 839. With the purpose of the HCQIA and its burden allocations in mind, the Court shall now examine Plaintiff's specific arguments as to why immunity should not attach to Defendants for the peer review actions taken against him.

1. Reasonable Belief that the Action Furthered Quality Health Care

Dr. Poliner contends that he has raised material issues of fact as to whether Defendants were motivated by something other than a reasonable belief that their actions would further the care of the Hospital's patients. More specifically, Plaintiff alleges that the combination of the personal animosity toward him and the desire to eliminate an economic competitor resulted in a conspiracy to eliminate plaintiff from practicing at PHD. In making this examination, most courts have adopted an objective standard of reasonableness. *See Brader*, 167 F.3d at 839; *see also Sugarbaker, M.D. v. SSM Health Care*, 190 F.3d 905, 912-913 (8th Cir. 1999) *cert. denied.* 528 U.S. 1137 (2000); *Mathews, M.D. v. Lancaster Gen. Hosp.*, 87 F.3d 624, 635 (3rd Cir. 1996); *Imperial v. Suburban Hosp. Ass'n, Inc.*, 37 F. 3d 1026, 1030 (4th Cir. 1994); *Egan v. Athol Memorial Hosp.*, 971 F. Supp. 37, 42 (D. Mass 1997), *affirmed* 134 F.3d 361 (1st Cir. 1998). That is, the focus of this inquiry is not whether the defendants' initial concerns are ultimately proven to be medically sound. Rather, the objective inquiry focuses on whether the professional action taken against plaintiff was taken "in the reasonable belief that the action was in the furtherance of quality health care." *See Sugarbaker*, 190 F.3d at 913.

In this case, the court finds that the summary judgment evidence creates a fact issue as to whether Dr. Poliner was summarily suspended on May 14, 1998. Defendants maintain that plaintiff agreed to an abeyance as provided in the hospital by-laws. However, the hospital by-laws require that the physician must agree to the abeyance. Art. VIII, Part C: Section 3(a). Dr. Poliner maintains he was told by Dr. Knochel that if he did not agree to the abeyance, plaintiff's privileges would be summarily suspended. Dr. Knochel testified in his deposition that he told plaintiff that the only alternative to the abeyance was suspension. Thus, there is a fact issue as to whether plaintiff agreed to an abeyance or was instead summarily suspended. Assuming for summary judgment purposes that the abeyance was instead a summary suspension, the court must then determine whether that action was taken in accordance with the HCQIA. The HCQIA provides that the requirement of adequate notice and hearing procedures do not preclude immediate suspension of privileges subject to subsequent notice and hearing "where the failure to take such an action may result in an imminent danger to the health of any individual." 42 U.S.C. § 1112(c)(2). PHD's Medical Staff by-laws provide summary suspensions may be made when the acts of a physician "present a danger to the health of this patients . . . ." However, the HCQIA does require that summary suspensions be made only after a reasonable effort to obtain the facts of the matter. At the time he offered plaintiff the abeyance, Dr. Knochel knew of the ongoing investigations by the IMAC and of the incident in the cath lab on May 12, 1998. However, Dr. Knochel could not have made the decision to summarily suspend Dr. Poliner on the basis of the complaints then before the IMAC. Those complaints were initially made in September, October and December 1997 and were still under investigation in May 1998. Thus, those complaints could not have been considered by Defendants as "constituting an imminent danger to the health" of plaintiff's patients. Defendants also knew of the May 12 incident in the emergency room concerning patient no. 36. However, before suspending plaintiff, defendants had not received the report from the IMAC, did not talk to Dr. Poliner about any specific complaints, and did not offer plaintiff the opportunity to give his side of the story and to address the concerns defendants had about plaintiff's conduct. Thus, if plaintiff was summarily suspended on May 14, 1998, the court finds there are fact issues as to whether defendants Levin, Harper, Knochel, and PHD: (1) acted in the reasonable belief that their action was in furtherance of quality health care; (2) acted after a reasonable effort to obtain the facts of the matter after procedures that were fair to Dr. Poliner under the circumstances; (3) reasonably believed immediate suspension was necessary because failure to act may have resulted in an imminent danger to the health of any person; and (4) acted with actual malice. Thus, defendants' Knochel, Levin, Harper, and PHD's motion for summary judgment is denied on the basis of immunity under the HCQIA.

Defendants Charles Harris, Anthony Das, David Musselman, Robert Brockie, Jorge Cheirif, Steven Meyer, and Martin Berk were sued by plaintiff because of their roles on the AHC or IMAC committee or because they participated in reviewing plaintiff's care of his patients. The court finds these defendants are entitled to summary judgment on the basis of the immunity provided by the HCQIA and the Texas Peer Review Immunity Statutes. As set forth above, the evidence establishes that the first documented review of plaintiff occurred after a nurse in the cath lab filled out a CERF against Dr. Poliner on September 29, 1997. Three CERFs were filed against Dr. Poliner by nurses in the cath lab in September, October, and

December 1997. By hospital policy, the CERFs were referred to the hospital's Clinical Risk Review Committee ("CRRC"). None of the defendants named in this suit were members of the CRRC. The CRRC reviewed two of the CERFs on January 12, 1998, identified several concerns with Dr. Poliner's patient care in the two cases, and referred the cases to the Internal Medicine Department for further review. The CRRC took up review of the CERF with respect to patient no. 9 on April 13, 1998, and that case was also referred to Internal Medicine Department. All three cases were then referred to the IMAC, the committee charged with investigating patient care concerns within the Internal Medicine Department. The IMAC was still reviewing the three cases involving Dr. Poliner when the May 12, 1998 incident involving patient no. 36 occurred. After obtaining the abeyance from plaintiff, Dr. Knochel appointed an Ad Hoc Committee ("AHC") composed of six cardiologists to review plaintiff's cath lab and echocardiogram privileges. The AHC was the hospital committee that performed the most thorough review of plaintiff's cases. Plaintiff asserts that the reviews were less than thorough and that the written reviews completed by the reviewing defendants were "so egregious that they are prima facie evidence of malice and intent to harm." (Plf.'s Brief in Resp. to Mot. For S.J. at 3). Plaintiff further argues that there is no evidence to establish that he was a danger to his patients at the time of his summary suspension on June 12, 1998. Plaintiff supports his argument with the testimony of several retained experts. After reviewing forty-four (44) of plaintiff's cases, the AHC concluded that plaintiff rendered substandard care in twenty-nine (29) of the cases. The IMAC then met to discuss the report of the

AHC. The IMAC was composed of several doctors only one of whom was a cardiologist. Thus, most of the members of the IMAC were not direct competitors of Dr. Poliner. The IMAC met and reviewed the report of the AHC and subsequently met and heard from Dr. Poliner. After hearing from the AHC and from Dr. Poliner, the IMAC voted unanimously to recommend suspension of Dr. Poliner's privileges on June 12, 1998. Following plaintiff's appeal of his suspension, the Hearing Committee heard evidence over portions of three days. The Hearing Committee recommended restoration of Dr. Poliner's privileges, but also concluded that the suspension of Dr. Poliner's privileges was justified under the circumstances then existing. Dr. Poliner has agreed that the members of the hearing committee were not his competitors. In sum, the record establishes that the CRRC, the IMAC, and the hearing committee all had concerns with some of Dr. Poliner's practices. The overwhelming majority of the doctors on those committee were not competitors of Dr. Poliner. The recommendations of the AHC and the IMAC were made only after review of some of plaintiff's files and after hearing from plaintiff. The court cannot overlook this evidence in favor of plaintiff's personal beliefs and the opinions of hired experts. Moreover, there is no evidence in the record that any of the doctors on the CRRC, the IMAC or the hearing committee had any personal animosity towards plaintiff. Plaintiff's evidence of malice as to these defendants consists of instances where the defendants disagree with a finding or course of treatment followed by plaintiff after review of the patients' files. The court does not find this evidence sufficient to raise a fact issue of malice with respect to these defendants. These defendants were doing what is customary in peer review processes, and plaintiff has not presented sufficient evidence to overcome the immunity conferred by the HCQIA.

2. Reasonable Fact Gathering

In order to qualify for HCQIA immunity, Defendants must also have made a reasonable effort to obtain the relevant facts. *See* 42 U.S.C. § 11112(a)(2). In assessing this issue, the Court must consider whether the totality of the process leading up to plaintiff's summary suspension evidenced a reasonable effort to obtain the facts of the matter. *See Matthews*, 87 F. 3d at 637; *see also Brader*, 167 F.3d at 831.

With respect to defendants Knochel, Harper, Levin and PHD, for the reasons stated above the court finds that their actions in summarily suspending plaintiff on May 14, 1998 were not made after a reasonable effort to obtain the facts in the case.

Plaintiff asserts here that the reviews conducted by the AHC were biased, incomplete, and filled with errors. Thus, plaintiff concludes those defendants did not make reasonable efforts to obtain the facts in this case. For reasons stated above, the court disagrees. Plaintiff's conclusion is drawn largely from the testimony of his experts. However, some of plaintiff's own experts acknowledged errors made by plaintiff. Additionally, plaintiff's arguments ignore that other doctors in the hospital, who were not direct competitors of plaintiff and who have not been shown to have had any ill will toward plaintiff, expressed concern with plaintiff's patient care. Plaintiff maintains that some of the personnel in the cath lab were upset with him because of the emergency nature of his practice, and because some believed that cases plaintiff treated as emergencies were not really emergencies. However, apart from this general speculation, plaintiff provides no evidence that the specific complaints made by the cath lab nurses were motivated by ill will. More importantly, there has been no showing that the CRRC's referrals to the IMAC of the three CERFs filed against plaintiff were motivated by ill will. The CRRC's referral of the complaints to the Internal Medicine Department indicates that legitimate concerns about patient care were involved. None of the members of the CRRC are defendants in this case. None of the doctors on the CRRC were direct competitors of plaintiff, and none have been shown to have had any animosity against plaintiff. Similarly, only one member of the IMAC could be seen as a direct competitor of plaintiff. There is no evidence that the other members of the IMAC had animosity against plaintiff. Yet these doctors, after reviewing the report from the AHC and after hearing from plaintiff, recommended unanimously that plaintiff's privileges be suspended. The same is true of the Hearing Committee that heard plaintiff's appeal of his suspension. Although the committee recommended that plaintiff's privileges be restored, the committee also found that the summary suspension of plaintiff's privileges was proper under the evidence known at the time.

On the record as a whole, the court finds that the actions taken by Defendants Harris, Das, Musselman, Brockie, Cheirif, Meyer, and Berk, were sufficient to constitute a "reasonable effort to obtain the facts."

3. Adequate Notice and Hearing

Plaintiff maintains that he was not afforded adequate notice and hearing procedures in accordance with the HCQIA. Plaintiff complains that he was given only one hour to review the cases with IMAC, and that he was never given the opportunity to meet with the AHC who conducted the reviews. Plaintiff also complains that only one cardiologist was on the IMAC. However, plaintiff has not shown that the absence of cardiologists on the IMAC rendered the peer review process fundamentally unfair to him. Additionally, the court notes that there were no cardiologists on the Hearing Committee that recommended restoring plaintiff's privileges. The HCQIA requires that "adequate notice and hearing procedures" be afforded to the physician involved. 42 U.S.C. § 111112(a)(3). However, the HCQIA also provides that the notice and hearing requirements of the statute do not "preclude an immediate suspension or restriction of clinical privileges, subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action may result in an imminent danger to the health of any individual." 42 U.S.C. § 11112(c). Plaintiff, relying on his testimony and the testimony of his experts, asserts that the defendants cannot show that imminent danger to any of his patients existed at the time of his summary suspension. For the reasons stated above, the court finds there is a fact issue with respect to plaintiff's summary suspension on May 14 1998.

However, the court finds that the actions of the AHC and the IMAC were taken after adequate notice to plaintiff and after a hearing. Plaintiff complains that he was given insufficient time to respond to twenty-nine complex cases before the IMAC. However, prior to the hearing with the IMAC, plaintiff was given a list of the cases with which the IMAC had concerns. Plaintiff was then provided access to all of the records pertaining to those cases. Additionally, the letter of abeyance given to plaintiff on May 14, 1998 identified concerns with plaintiff's treatment of patients nos. 3, 9, 18, and 36. The immediate danger to patient safety concerns resulted from Dr. Poliner's treatment of patient no. 36. Although the abeyance letter did not specify the concerns with those patients, plaintiff had notice of concerns with those cases for almost four weeks prior to the hearing before the IMAC. Dr. Steven Rinner, an internist on the IMAC, identified the case of patient no. 36 as the one that concerned him the most and the reason that Dr. Rinner considered plaintiff a danger to his patients. The court cannot find on the record of this case that the proceedings of the AHC and the IMAC were such that plaintiff was not given a meaningful opportunity to address the concerns raised against him. Dr. Poliner requested additional time from Dr. Knochel to respond to the issues raised, and Dr. Knochel denied the request. However, there is no evidence that plaintiff asked the IMAC for additional time to respond or informed the IMAC that he had been given insufficient time to respond to the concerns raised about his patient care. On the record as a whole, the court concludes that Plaintiff was afforded adequate notice and hearing as required under the HCQIA with respect to the actions of the AHC and the IMAC. Accordingly, the defendant doctors on those committees are entitled to immunity, and summary judgment is granted in favor of defendants Harris, Das, Musselman, Brockie, Cheirif, Meyer, and Berk as to all of plaintiff's state law claims against these defendants.

B. Texas Peer Review Immunity Statutes

In addition to the immunities granted by the HCQIA, the Act itself allows individual states to provide even further protection to medical peer review activities. *See Roe v. Walls Regional Hosp., Inc.*, 21 S.W.3d 647, 652 (Tex. Civ. App.- Waco 2000). Specifically, the HCQIA provides that: "nothing in this subchapter shall be construed as changing the liabilities or immunities under law or as preempting or overriding any State law which provides incentives, immunities, or protection for those engaged in a professional review action that is in addition to or greater than that provided by this subchapter." 42 U.S.C. § 11115(a); *see also St. Luke's Episcopal Hosp. v. Agbor*, 952 S.W.2d 503, 507 (Tex. 1997) ("even if the Federal Act does not apply . . . this provision specifically allows states to implement their own initiatives to provide greater immunities in professional review actions than those the Federal Act provides").

To this end, the Texas Legislature in 1987 enacted section 5.06 of the Texas Medical Practice Act ("TMPA"), which under section 5.06 provided:

> (*l*) A cause of action does not accrue against the members, agents, or employees of a medical peer review committee or against the health-care entity from any act, statement, determination or recommendation made, or act

> reported, without malice, in the course of peer review as defined by this Act.
> (m) A person, health-care entity, or medical peer review committee, that, without malice, participates in medical peer review actively or furnishes records, information, or assistance to a medical peer review committee or the board is immune from any civil liability arising from such an act.

See Roe, 21 S.W.3d at 653 (*citing* Tex. Rev. Civ. Stat. Ann. art. 4495b § 5.06(*l*), (m) (repealed)). Thereafter, in 1989, the Texas Legislature enacted sections 161.031-161.033 of the Health and Safety Code, extending peer review immunity to members of a "medical committee":

> A member of a medical committee is not liable for damages to a person for an action taken or recommendation made within the scope of the functions of the committee if the committee member acts without malice and in the reasonable belief that the action or recommendation is warranted by the facts known to the committee member.

See Roe, 21 S.W.3d at 65 *(citing* Tex. Health & Safety Code Ann. § 161.033 (Vernon 1992).

Currently codified in the Texas Occupations Code, immunity from civil liability is provided to:

> (1) a person who, in good faith, reports or furnishes information to a medical peer review committee or the board;

> (2) a member, employee or agent of the board, a medical peer review committee, or a medical organization district or local intervenor, who takes an action or makes a recommendation within the scope of the functions of the board, committee, or intervenor program, *if that member, employee, agent, or intervenor acts without malice and in the reasonable belief that the action or recommendation is warranted by the facts known to that person;* and
> (3) a member or employee of the board or any person who assists the board in carrying out its duties or functions provided by law.

Tex. Occ. Code Ann. § 160.010 (a) (Vernon 2001) (emphasis added). As such, Texas has clearly taken the additional step of providing for more protection to the activity of medical peer reviews than those which the HCQIA provides. *See Roe,* 21 S.W.3d at 653 (citing *Agbor,* 952 S.W.2d at 507). Thus, the qualified immunity from liability conferred by these statutes to defendants can be defeated only by a showing that they acted with actual malice. *See Id.* The court now turns to the issue of whether plaintiff has provided summary judgment evidence raising a genuine issue of material fact on the question of malice.

C. Malice

In the context of the Texas peer review immunity statutes, actual malice is the standard by which defendants' conduct is measured. *Johnson v. Hospital Corp. of America,* 95 F.3d 383, 395 (5th Cir. 1996). Actual malice means "the making of a statement with knowledge that it is false, or with reckless disregard of whether it is true." *Duffy v. Leading Edge Products, Inc.*, 44 F.3d 308 at 313 (5th Cir. 1995) (internal citations and quotations omitted). "Reckless disregard" means that a statement is made with "a high degree of awareness of probable falsity." *Id.* When a qualified privilege is asserted as an affirmative defense, which the defendants have done, whether the statements are true is of no moment, unless there is clear evidence of actual malice. A plaintiff must show that the defendant acted with actual malice in order to overcome the affirmative defense of qualified privilege. *ContiCommodity Services, Inc. v. Ragan,* 63 F.3d 438, at 443 (5th Cir. 1995). If a fact question exists whether a statement or comment was made with actual malice, that statement automatically loses qualified privilege status, and summary judgment would be inappropriate. *See Bozéé v. Branstetter,* 912 F.2d 801, 807 (5th Cir. 1990). In the context of the summary judgment motion, plaintiff must raise a fact issue of actual malice rather than defendants prove the absence of malice. *Duffy v. Leading Edge,* 44 F.3d at 314. "Negligence, lack of investigation, or failure to act as a reasonably prudent person are insufficient to show actual malice." *Id.*, at 313 (citing *Shearson Lehman Hutton, Inc. v. Tucker,* 806 S.W.2d 914, 924 (Tex. Civ. App.- Corpus Christi 1991, writ dismissed w.o.j.)). However, inadequate investigation coupled with the presence of ulterior motives may be sufficient to raise a fact issue as to actual malice. *Id.* at 315.

In the present case, there is not simply a claim of inadequate investigation, but a complete failure to investigate and to gather all of the facts from both sides before Dr. Knochel summarily suspended plaintiff's privileges by telling plaintiff to sign the abeyance letter or face immediate suspension. Viewing the summary judgment in light most favorable to plaintiff, there is evidence that defendants Knochel, Harper, Levin, and PHD violated their own bylaws as well as the HCQIA in summarily suspending Dr. Poliner's privileges. Additionally, plaintiff presents evidence that some of the defendants involved in the summary suspension of May 14 harbored animosity against plaintiff. Thus, the court finds that a fact issue exists with respect to whether defendants Knochel, Harper, Levin and PHD acted with actual malice. These defendants' motion for summary judgment on the basis of immunity conferred by the Texas peer review statutes is denied.

With respect to defendants Harris, Das, Musselman, Brockie, Cheirif, Meyer, and Berk, the court finds plaintiff has failed to raise an issue of malice, and summary judgment is granted in favor of these defendants as to all of plaintiff's state law claims against them.

VII. Interference with Contractual Relations

Plaintiff brings a related claim against all the Defendants for the wrongful and intentional interference with his business and contractual relationships with his existing and prospective patients. *See* Pl.'s Third Amend. Compl. at ¶¶ 123-127. To recover for tortious interference with an existing contract, the plaintiff must prove: (1) the existence of a contract subject to interference, (2) the act of interference was willful and intentional, (3) such intentional act was a proximate cause of plaintiff's damage and (4) actual damage or loss occurred. *See*

Johnson v. Hospital Corp. of America, 95 F.3d 383, 394 (5th Cir. 1996) (citing *Victoria Bank & Trust Co. v. Brady*, 811 S.W.2d 931, 939 (Tex. 1991). Having determined that fact issues exist with respect to whether defendants Knochel, Levin, Harper and PHD acted with malice, the court denies these defendants' motion on the grounds that their conduct was privileged or protected by the peer review immunity statutes. Additionally, there is a fact issue as to whether defendants wrongfully suspended plaintiff's privileges. If the jury finds that defendants wrongfully suspended plaintiff's privileges, this would satisfy the independent tort requirement of *Wal-Mart Stores, Inc. v. Sturges*, 52 S.W.3d 711 (Tex. 2001). Defendants Harris, Das, Musselman, Brockie, Cheirif, Meyer, and Berk's motion for summary judgment as to plaintiff's tortious interference with business claim is granted since plaintiff has not established a fact issue that these defendants acted with malice.

VIII. Defamation and Business Disparagement Claims

Defendants move for summary judgment on the grounds that the personal defamation claims are barred by the one year statute of limitations. With respect to the business disparagement claims, defendants assert that the allegedly defamatory statements were true and the statements were entitled to a qualified privilege. To sustain a claim involving statements that enjoy a qualified privilege, plaintiff must show that defendants' publication of the statements was motivated by actual malice at the times the statements were made.

Plaintiff concedes that the personal defamation claims are subject to a one year statute of limitations. However, Plaintiff maintains that each publication of the statements gives rise to a separate cause of action. *Carr v. Mobile Video Tapes, Inc.*, 893 S.W.2d 613, 619 (Tex. App.- Corpus Christi 1995, no writ). Additionally, plaintiff alleges that he was forced to publish his suspension of privileges when he has applied or reapplied for privileges and to state agencies and to third party payors. Texas courts recognize the narrow category of cases of self-compelled defamation. *Purcell v. Seguin State Bank and Trust Co.* 999 F.2d 950, 959 (5th Cir. 1993). Plaintiff presents evidence of publication within one year of the filing of this suit. Defendants' Knochel, Levin, Harper and PHD's motion for summary judgment as to plaintiff's personal defamation claims is denied.

With respect to the business disparagement claims, the court has previously found that a fact issue exists as to whether defendants acted with actual malice. Thus, even if the statements enjoy a qualified privilege, the existence of a fact issue on the issue of actual malice precludes summary judgment for these defendants on this claim. Defendants also contend that the statements concerning Dr. Poliner's suspension were true. However, the court has determined that a fact issue exists as to whether defendants suspended plaintiff because of a belief of an imminent danger to plaintiff's patients or for other reasons. Hence, defendants' Knochel, Levin, Harper and PHD's motion for summary judgment with respect to plaintiff's business disparagement claims is denied. Summary judgment is granted in favor of defendants Harris, Das, Musselman, Brockie, Cheirif, Meyer, and Berk on plaintiff's personal defamation and business disparagement claims.

IX. INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS

To recover on a claim of Intentional Infliction of Emotional Distress, a plaintiff must establish that 1) the defendant acted intentionally or recklessly, 2) the conduct was "extreme and outrageous", 3) the actions of the defendant caused plaintiff emotional distress, and 4) the resulting emotional distress was severe. *Twyman v. Twyman,* 855 S.W.2d 619, 621-22 (Tex. 1993). Whether a defendant's conduct is extreme and outrageous is a question of law. *Brewerton v. Dalrymple*, 997 S.W.2d 212, 216 (Tex. 1999). The fact that a defendant's conduct is tortious or otherwise wrongful does not, standing alone, necessarily render it extreme and outrageous. *id.* To be extreme and outrageous, a defendant's conduct must be "so outrageous in character, and so extreme in degree, as to go beyond all possible bounds of decency, and to be regarded as atrocious, and utterly intolerable in a civilized community." *GTE Southwest, Inc. v. Bruce,* 998 S.W.2d 605, 611 (Tex. 1999).

Because the court has found that a fact issue exists as to whether defendants Knochel, Levin, Harper, and PHD acted with actual malice, summary judgment is denied as to these defendants on plaintiff's intentional infliction of emotional distress claim. However, summary judgment is granted in favor of defendants Harris, Das, Musselman, Brockie, Cheirif, Meyer, and Berk on this claim.

X. Deceptive Trade Practices Act Claims

Defendants move for summary judgment on plaintiff's Texas Deceptive Trade Practices Act claim on the grounds that plaintiff is not a consumer under the TDPA. A "consumer" under the TDPA is someone who sought or acquired, by purchase or lease, goods or services. *Amstadt v. U.S. Brass Corp.*, 919 S.W.2d 644, 649 (Tex. 1996). The summary judgment evidence does not establish that plaintiff is consumer of the hospital with respect to his privileges at the hospital. Clearly, plaintiff was not a consumer with respect to the individual defendants in this case. Summary judgment is granted in favor of all defendants on plaintiff's TDPA claim.

XI. Miscellaneous Motions

Plaintiff filed a motion to amend complaint on July 11, 2002 seeking to include as a plaintiff in this case Lawrence Poliner, M.D., P.A., a sub-chapter S corporation organized under the laws of the State of Texas wholly owned by Dr. Poliner. Defendants object to the amendment asserting the amendment is untimely and prejudicial to defendants. Federal Rule of Civil Procedure 15(a) provides for amendment by leave of court and requires that leave be freely granted when justice requires. Plaintiff's proposed amendment does not add new claims or theories of recovery. It appears that defendants have known of the existence of the P.A. for some time, and the court does not find that allowing the amendment will cause prejudice to defendant. Plaintiff's motion to amend complaint is GRANTED.

Defendants' objections to plaintiff's summary judgment evidence and plaintiff's supplemental summary judgment evidence are DENIED as moot except where the court finds it necessary to rule on a specific objection in deciding this motion for summary judgment. Defendants also filed a motion to limit the number of expert witnesses. In light of the court's rulings on this motion for summary judgment, the testimony of some of these experts may no longer be necessary. Accordingly, defendants' motion is DENIED at this time. The court, however, cautions the parties about presenting unnecessary, cumulative evidence. The court will revisit the issue of limiting the number of expert witnesses at the pretrial conference, or by motion, if raised by the parties. However, any ruling limiting the number of experts will not be on the basis of when depositions of the experts were taken.

So Ordered.

Signed this 30th day of September 2003.

/s/Jorge A. Solis
Jorge A. Solis
United States District Judge

APPENDIX E

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF TEXAS DALLAS DIVISION

CIVIL ACTION NO. 3-00-CV-1007-P

[Filed August 26, 2004]

LAWRENCE R. POLINER, M.D., and)
LAWRENCE R. POLINER, M.D., P.A.,)
)
Plaintiffs,)
)
v.)
)
TEXAS HEALTH SYSTEMS, A TEXAS)
NON-PROFIT CORPORATION, d/d/a)
PRESBYTERIAN HOSPITAL OF DALLAS;)
JAMES KNOCHEL, M.D., CHARLES)
LEVIN, M.D.; and JOHN HARPER, M.D.,)
)
Defendants.)

COURT'S CHARGE TO THE JURY

MEMBERS OF THE JURY:

Now that you have heard all of the evidence, it becomes my duty to give you the instructions of the Court concerning the law applicable to this case.

It is your duty as jurors to follow the law as I shall state it to you, and to apply that law to the facts as you find them from the evidence in the case. You are not to single out one instruction alone as stating the law, but must consider the instructions as a whole. Neither are you to be concerned with the wisdom of any rule of rule stated by me.

Regardless of any opinion you may have as to what the law is or ought to be, it would be a violation of your sworn duty to base a verdict upon any view of the law other than that given in the instructions of the Court, just as it would also be a violation of your sworn duty, as judges of the facts, to base a verdict upon anything other than the evidence in the case.

In deciding the facts of this case, you must not be swayed by bias or prejudice or favor as to any party. A corporation and all other persons are equal before the law and must be treated as equals in a court of justice. Our system of law does not permit jurors to be governed by prejudice or sympathy or public opinion. Both the parties and the public expect that you will carefully and impartially consider all of the evidence in the case, follow the law as stated by the Court in these instructions, and reach a just verdict regardless of the consequences.

A corporation is responsible for the acts of its officers, agents, or employees that are done within the scope of their authority delegated to them by the corporation, or within the scope of their duties as employees of the corporation. An "employee" is a person in the service of another with the understanding, express or implied, that such other person has the right to direct the details of the work and not merely the result sought to be accomplished. A party is an "agent" of another party if the party acts with the other party's authority. Authority for another to act for a party must arise from the party's agreement that the other act on behalf and for the benefit of the party. If a party so authorizes another to perform an act, that other party is also authorized to do whatever else is proper, usual, and necessary to perform the act expressly authorized.

As stated earlier, it is your duty to determine the facts, and in so doing you must consider only the evidence I have admitted in the case. The term "evidence" includes the sworn testimony of the witnesses, the exhibits admitted in the record, and stipulated facts. Stipulated facts must be accepted as proven facts. Any evidence as to which an objection was sustained by the Court and any evidence ordered stricken by the Court, must be entirely disregarded.

Remember that any statements, objections or arguments made by the lawyers are not evidence in the case. The function of the lawyers is to point out those things that are most significant or most helpful to their side of the case, and in so doing, to call your attention to certain facts or inferences that might otherwise escape your notice. In the final analysis, however, it is your own recollection and interpretation of the evidence that controls in the case. What the lawyers say is not binding upon you.

Generally speaking, there are two types of evidence which a jury may consider in properly finding the truth as to the facts in this case. One is "direct" evidence – such as testimony of an eyewitness. The other is "indirect" or "circumstantial" evidence – the proof of a chain of circumstances which points to the existence or nonexistence of certain facts. As a general rule, the law makes no distinction between direct and circumstantial evidence, but simply requires that the jury find the facts from a preponderance of all the evidence, both direct and circumstantial.

So, while you should consider only the evidence in the case, you are permitted to draw such reasonable inferences from the testimony and exhibits as you feel are justified in the light of common experience. In other words, you may make deductions and reach conclusions which reason and common sense lead you to draw from the facts which have been established by the testimony and evidence in the case.

Now, I have said that you must consider all of the evidence. This does not mean, however, that you must accept all of the evidence as true or accurate. You are the sole judges of the credibility or "believability" of each witness and the weight to be given to his or her testimony. In weighing the testimony of a witness, you should consider his or her relationship to Plaintiff or to Defendant; his or her interest, if any, in the outcome of the case; his or her manner of testifying; his or her opportunity to observe or acquire knowledge concerning the facts about which he or she testified; his or her candor; fairness and intelligence; and the extent to which he or she has been supported or contradicted by other credible evidence. You may, in short, accept or reject the testimony of any witness in whole or in part.

Also, the weight of the evidence is not necessarily determined by the number of witnesses testifying as to the existence or nonexistence of any fact. You may find that the testimony of a smaller number of witnesses as to any fact is more credible than the testimony of a larger number of witnesses to the contrary.

During the trial of this case, certain testimony has been read to you by way of depositions, consisting of sworn answers to questions asked of the witnesses in advance of trial. Such testimony is entitled to the same consideration and is to be judged as to credibility, and weighed, and otherwise considered by the jury in the same way, insofar as possible, as if the witness had been present and had given from the witness stand the same testimony as given in the deposition.

I will instruct you as to which party has the burden of proof on each essential element of its claim in the case. The party having the burden of proof on each issue of fact must prove that fact by a "preponderance of the evidence." A preponderance of the evidence means such evidence as, when considered and compared with that opposed to it, has more convincing force and produces in your minds a belief that what is sought to be proved is more likely true than not true. In other words, to establish a claim by a preponderance of the evidence merely means to prove that the claim is more likely so than not so.

In determining whether any fact in issue has been proved by a preponderance of the evidence, you the jury may consider the testimony of all the witnesses, regardless of who may have called them, and all the exhibits received in evidence, regardless of who may have introduced them. If the proof should fail to establish any essential element of Plaintiffs' claim by a preponderance of the evidence, the jury should find for Defendants as to that claim. If the proof should fail to establish by a preponderance of the evidence any essential element of a defense raised by the Defendants, the jury should find for the Plaintiffs as to that defense.

A witness may be "impeached" or discredited by contradictory evidence, by a showing that he or she testified falsely concerning a material matter, or by evidence that at some other time be or she said or did something, or failed to say or do something, which is inconsistent with the witness' present testimony.

If you believe that any witness has been so impeached, it is in your exclusive province to give the testimony of that wittness such credibility or weight, if any, as you think it deserves.

In answering the questions which I will submit to you, answer "yes" or "no" unless otherwise instructed. A "yes" answer must be based on a preponderance of the evidence. If you do not find that a preponderance of the evidence supports a "yes" answer, then answer "no."

You should not interpret the fact that I have given instructions about Plaintiffs' damages as an indication in any way that I believe that Plaintiffs should, or should not, win this case.

After I have completed reading these instructions and reviewing the verdict form and jury questions with you, counsel will have the opportunity to make their closing arguments.

Your verdict must represent the considered judgment of each juror. In order to return a verdict, it is necessary that all members of the jury agree to each question. You therefore may not enter into an agreement to be bound by a majority or any vote other than a unanimous one.

Remember at all times that you are not partisans. Rather, you are judges – judges of the facts. Your sole interest is to seek the truth from the evidence in the case.

Upon retiring to the jury room, you should first select one juror to act as your presiding officer who will preside over your deliberations and will be your spokesperson here in Court. A verdict form has been prepared for your convenience. Your presiding officer will sign in the space provided below after you have reached your verdict.

If, during your deliberations, you wish to communicate with the Court, you should do so only in writing by a note handed to the Deputy Marshal and signed by the presiding officer. During your deliberations, you will set your own work schedule, deciding for yourselves when and how frequently you wish to recess and for how long.

After you have reached your verdict, you will return these instructions together with your written answers to the questions that I will submit to you. Do not reveal your answers until such time as you are discharged, unless otherwise directed by me.

Date: August 26th, 2004.

/s/
JORGE A. SOLIS
UNITED STATES DISTRICT JUDGE

HEALTH CARE QUALITY IMPROVEMENT ACT ("HCQIA")

HCQIA was passed by Congress to improve the quality of medical care by encouraging physicians to identify and discipline physicians who are incompetent or who engage in unprofessional behavior. This process is referred to as peer review. As you are aware, this lawsuit arises from Plaintiffs' claim that the Defendants misused the peer review process when his privileges were suspended on May 14, 1998 and on May 29, 1998.

Plaintiffs claim that the Defendants' actions on or before May 14, 1998 and on May 29, 1998 were in reality a suspension of his privileges because he only signed the abeyance under the threat of immediate suspension of all of his privileges. Defendants claim that Dr. Poliner voluntarily agreed to accept the abeyance.

HCQIA provides that an immediate suspension or restriction of clinical privileges may be made, subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action may result in an imminent danger to the health of any individual. The Presbyterian Medical Staff Bylaws provide that when the acts of a practitioner through his lack of competence, or failure to care adequately for his patients constitutes a present danger to the health of his patients, all or any of the clinical privileges of a practitioner may be summarily suspended. Under the law, Defendants had the legal right to suspend or to threaten to suspend Dr. Poliner's privileges on May 14, 1998 and on May 29, 1998 if the failure to take such an action may have resulted in an imminent danger to the health of any individual or if Dr. Poliner constituted a present danger to the health of his patients. In determining whether the Defendants are entitled to the immunity afforded by the HCQIA, you must only consider the events and actions that occurred on or before May 14, 1998 and May 29, 1998.

QUESTION NO. 1

Plaintiff has the burden of proof on this question. Do you find by a preponderance of the evidence that the Defendants did not have a reasonable belief on or before May 14, 1998 or May 29, 1998 that Dr. Poliner posed an imminent danger to the health of any individual or that Dr. Poliner constituted a present danger to the health of his patients?

Answer "Yes, the Defendants did not have a reasonable belief" or "No, the Defendants did have a reasonable belief".

James Knochel, M.D.

May 14, 1998 ANSWER: Yes

May 29, 1998 ANSWER: Yes

Charles Levin, M.D.

May 14, 1998 ANSWER: Yes

May 29, 1998 ANSWER: Yes

John Harper, M.D.

May 14, 1998 ANSWER: Yes

May 29, 1998 ANSWER: Yes

Presbyterian Hospital

May 14, 1998 ANSWER: Yes

May 29, 1998 ANSWER: Yes

If you have answered "No" as to all Defendants in Question No. 1, proceed to the last page entitled Certificate, sign the verdict form, and do not answer any further questions. If you have answered "Yes" as to any Defendant in Question No. 1, proceed to the section entitled Abeyance and answer Question No. 2.

ABEYANCE

The Medical Staff Bylaws provide that in order to constitute an abeyance, the action affecting Dr. Poliner's privileges must be agreed to by him. If you find by a preponderance of the evidence that Dr. Poliner's agreement to the May 14, 1998 letter or to the May 29, 1998 letter was caused by duress, if any, imposed by the Defendants, you may not find that Dr. Poliner agreed to the abeyance. Duress is the mental, physical, or economic coercion of another, causing that party to act contrary to his or her free will and interest.

QUESTION NO. 2

Do you find by a preponderance of the evidence that Dr. Poliner did not agree to the abeyance on May 14, 1998 or on May 29, 1998?

Answer "Yes, Dr. Poliner did not agree to the abeyance" or "No, Dr. Poliner did agree to the abeyance" as to May 14, 1998.

ANSWER: Yes

Answer "Answer "Yes, Dr. Poliner did not agree to the abeyance" or "No, Dr. Poliner did agree to the abeyance" as to May 29, 1998.

ANSWER: Yes

Proceed to the section entitled HCQIA Immunity and answer Question No. 3.

HCQIA IMMUMITY

The HCQIA provides that if a professional review action meets the standards set forth below, then the professional review body, any person acting as a member or staff to the body, any person under a contract or other formal agreement with the body, and any person who participates with or assists the body with respect to the action, shall not be liable in damages under any law of the United States or of any State with respect to the action. Specifically, a professional review action must be taken:

> (1) in the reasonable belief that the action was in the furtherance of quality health care,
> (2) after a reasonable effort to obtain the facts of the matter,
> (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
> (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

A "professional review action" is an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician. You are instructed that the actions of Defendants with respect to the suspension of Dr. Poliner's cardiac catheterization lab privileges on May 14, 1998 and May 29, 1998 were "professional review actions" pursuant to the provisions of federal law cited above.

A "professional review activity" is an activity of a health care entity with respect to an individual physician –

(a) to determine whether the physician may have clinical privileges with respect to, or membership in, the entity,
(b) to determine the scope or conditions of such privileges or membership, or
(c) to change or modify such privileges or membership.

A "professional review body" is a health care entity and the governing body or any committee of a health care entity which conducts professional review activity, and includes any committee of the medical staff of such an entity when assisting the governing body in a professionnl review activity.

To satisfy the first element, you must be satisfied that Defendants, with the information available to them at the time of the professional review action, would reasonably have concluded that their actions would restrict incompetent behavior or would protect patients.

In determining whether the Defendants made a reasonable effort to obtain the facts of the matter, you must consider the totality of the process leading up to the suspension of Dr. Poliner's cardiac catheterization lab privileges on May 14, 1998 and on May 29, 1998.

QUESTION NO. 3

Do you find by a preponderance of the evidence that the suspension of Dr. Poliner's cardiac catheterization lab privileges on May 14, 1998 and on May 29, 1998 was not undertaken:

(1) in the reasonable belief that the action was in the furtherance of quality health care?

Answer "Yes, it was not undertaken" or "No, it was undertaken" as to each Defendant.

James Knochel, M.D.

May 14, 1998 ANSWER: Yes
May 29, 1998 ANSWER: Yes

Charles Levin, M.D.

May 14, 1998 ANSWER: Yes
May 29, 1998 ANSWER: Yes

John Harper, M.D.

May 14, 1998 ANSWER: Yes
May 29, 1998 ANSWER: Yes

Presbyterian Hospital

May 14, 1998 ANSWER: Yes
May 29, 1998 ANSWER: Yes

(2) after a reasonable effort to obtain the facts of the matter?

Answer "Yes, it was not undertaken" or "No, it was undertaken" as to each Defendant.

James Knochel, M.D.

May 14, 1998 ANSWER: Yes
May 29, 1998 ANSWER: Yes

Charles Levin, M.D.

May 14, 1998 ANSWER: Yes
May 29, 1998 ANSWER: Yes

John Harper, M.D.

May 14, 1998 ANSWER: Yes
May 29, 1998 ANSWER: Yes

Presbyterian Hospital

May 14, 1998 ANSWER: Yes
May 29, 1998 ANSWER: Yes

(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances?

Answer "Yes, it was not undertaken" or "No, it was undertaken" as to each Defendant.

James Knochel, M.D.

May 14, 1998 ANSWER: Yes
May 29, 1998 ANSWER: Yes

Charles Levin, M.D.

May 14, 1998 ANSWER: Yes
May 29, 1998 ANSWER: Yes

John Harper, M.D.

May 14, 1998 ANSWER: Yes
May 29, 1998 ANSWER: Yes

Presbyterian Hospital

May 14, 1998 ANSWER: Yes
May 29, 1998 ANSWER: Yes

(4) and in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3)?

Answer "Yes, it was not undertaken" or "No, it was undertaken" as to each Defendant.

James Knochel, M.D.

May 14, 1998 ANSWER: Yes
May 29, 1998 ANSWER: Yes

Charles Levin, M.D.

May 14, 1998 ANSWER: Yes
May 29, 1998 ANSWER: Yes

John Harper, M.D.

May 14, 1998 ANSWER: Yes
May 29, 1998 ANSWER: Yes

Presbyterian Hospital

May 14, 1998 ANSWER: Yes
May 29, 1998 ANSWER: Yes

If you have answered "Yes, it was not undertaken" to any Defendant as to any part of Question No. 3, proceed to the section entitled Texas Peer Review Immunity Statutes and answer Question No. 4. If you have answered "No, it was undertaken" as to each Defendant as to all parts of Question No. 3, proceed to the last page entitled Certificate, sign the verdict form, and do not answer any further questions.

TEXAS PEER REVIEW IMMUMTY STATUTES

In addition to the requirements of HCQIA, Texas law provides that a person, in good faith or without malice, who reports or furnishes information to a medical peer review committee, is immune from civil liability. Texas law further provides immunity from civil liability to a member of a medical peer review committee who takes an action within the scope of the functions of the committee, if that employee or agent acts without malice and in the reasonable belief that the action is warranted by the facts known to that person.

Malice is the making of a statement with knowledge that it is false, or with reckless disregard of whether it is false. Reckless disregard means that a statement is made with a high degree of awareness of probable falsity.

You are instructed that the actions of the Defendants in connection with May 14, 1998 and May 29, 1998 were actions taken in the course of medical peer review as provided by Texas state law described above.

QUESTION NO. 4

Do you find by a preponderance of the evidence that any of the following Defendants took an action within the scope of the functions of a medical peer review committee, with malice and not in the reasonable belief that the action was warranted by the facts known to that person?

Answer "Yes, Defendant acted with malice and not in the reasonable belief" or "No, Defendant acted without malice and in the reasonable belief" as to each Defendant.

James Knochel, M.D.

ANSWER: Yes

Presbyterian Hospital

ANSWER: Yes

Do you find by a preponderance of the evidence that any of the following Defendants, with malice and not in good faith, reported or furnished information to a medical peer review committee?

Answer "Yes, Defendant acted with malice and not in good faith" or "No, Defendant acted without malice and in good faith" as to each Defendant.

Charles Levin, M.D.

ANSWER: Yes

John Harper, M.D.

ANSWER: Yes

If you have answered "Yes" as to any Defendant listed in Question No. 4, proceed to the section entitled Release and answer Question No. 5. If you have answered "No" as to all Defendants listed in Question No. 4, proceed to the last page entitled Certificate, sign the verdict form, and do not answer any further questions.

RELEASE

Defendants claim that Dr. Poliner released any claims he had against Defendants by virtue of the language in Dr. Poliner's Application for Appointment. Dr. Poliner's Application for Appointment signed on May 30, 1996 extends immunity to, releases, and holds harmless from any and all liability Presbyterian Hospital, its representatives, and its Medical Staff for summary suspensions made in good faith and without malice.

QUESTION NO. 5

Defendants have the burden of proof on this question. Do you find by a preponderance of the evidence that the Defendants' suspension of Dr. Poliner's cardiac catheterization privileges on or before May 14, 1998 and May 29, 1998 were made in good faith and without malice, and thus, effectively released Defendants from all claims asserted by Plaintiffs?

Answer "Yes" or "No".

May 14, 1998 ANSWER: No

May 29, 1998 ANSWER: No

If you have answered "Yes" to Question No. 5, proceed to the last page entitled Certificate, sign the verdict form, and do not answer my further questions. If you have answered "No" to Question No. 5, proceed to the section entitled Breach of Contract Damages and answer Question No. 6.

BREACH OF CONTRACT DAMAGES

Answer Question No. 6 only if you have answered "Yes" as to any Defendant in Questions No. 1 and 2.

QUESTION NO. 6

What sum of money, if any, if paid now in cash, would fairly and reasonably compensate Dr. Poliner for his damages, if any, that resulted from Presbyterian Hospital's failure to comply with its Bylaws?

In answering this question, you may only consider damages, if any, that resulted from the actions of Defendants occurring on or before May 14, 1998 and May 29, 1998. You may not, however, consider damages that stem from any action taken on or after June 12, 1998. Do not add any amount for interest on damages, if any.

Answer in dollars md cents for damages, if any

loss of earnings Answer: 30,000,000.00

Proceed to the section entitled Defamation and answer Question No. 7.

DEFAMATION

Defamation is a defamatory statement orally communicated or published to a third person without legal excuse. Defamation is divided into two categories: libel and slander. Libel is the publication of a written statement without legal excuse, whereas slander is the publication of an oral statement without legal excuse.

In order to recover on his claim of defamation, Dr. Poliner must prove by a preponderance of the evidence that Defendants published a defamatory statement concerning Dr. Poliner. A defamatory statement is one in which the words tend to damage a person's reputation, exposing him or her to public hatred, contempt, ridicule, or financial injury, or deterring third persons from associating or dealing with him.

A statement is published if it is communicated orally, in writing, or in print to some third person capable of understanding their defamatory import and in such a way that the third person did so understand. A defamatory statement can be published by conduct. A statement is published by conduct when the communication is made and understood without words. To be actionable in defamation, a statement must contain an assertion of an objectively verifiable fact. Self-publication occurs when the plaintiff communicates a defamatory statement to a third party. An exception to the rule that the defendant must publish a statement exists when a reasonably prudent person would have expected that the plaintiff would communicate the defamatory statement to a third party.

QUESTION NO. 7

Do you find by a preponderance of the evidence that any of the following Defendants published a defamatory statement referring to Dr. Poliner in connection with the suspension of Dr. Poliner's cardiac catheterization privileges on or before May 14, 1998 or May 29, 1998?

Answer "Yes" or "No" as to each Defendant you answered "Yes" to in Question No. 4.

James Knochel, M.D.

ANSWER: Yes

Charles Levin, M.D.

ANSWER: Yes

John Harper, M.D.

ANSWER: Yes

Presbyterian Hospital

ANSWER: Yes

If you have answered "Yes" as to any Defendant in Question No. 7, proceed to answer Question No. 8. If you have answered "No" as to all Defendants in Question No. 7, proceed to the section entitled Business Disparagement and answer Question No. 12.

QUESTION NO. 8

Defendants have the burden of proof on this question. With respect to the defamatory statements found in Question No. 7, do you find by a preponderance of the evidence that all such defamatory statements were true?

Answer "Yes" or "No".

ANSWER: No

If you have answered "No" to Question No. 8, proceed to answer Question No. 9. If you have answered "Yes" to Question No. 8, proceed to the section entitled Business Disparagement and answer Question No. 12.

DEFAMATION PER SE

Defamation *per se* consists of defamatory statements so obviously hurtful to the person aggrieved that they require no proof of their injurious character to make them actionable. To maintain a claim for defamation *per se,* the defamatory statement must involve the imputation of serious misconduct or impropriety (such as the commission of a crime), or that the statement must affect a person injuriously in his or her office, profession, or occupation.

QUESTION NO. 9

Do you find by a preponderance of the evidence that any of the following Defendants published a statement referring to Dr. Poliner that was defamatory *per se* in connection with the peer review action taken on or before May 14, 1998 or May 29, 1998?

Answer "Yes" or "No" as to each Defendant you answered "Yes" to in Question No. 4.

James Knochel, M.D.

ANSWER: Yes

Charles Levin, M.D.

ANSWER: Yes

John Harper, M.D.

ANSWER: Yes

Presbyterian Hospital

ANSWER: Yes

Regardless of whether you have answered "Yes" or "No" to Question No. 9, proceed to answer Question No. 10.

QUALIFIED PRIVILEGE

As a defense to libel or slander, a qualified privilege extends to communications made in good faith on a subject in which the author has an interest or duty to another person having a corresponding interest or duty. The qualified privilege is lost, however, if the defamatory statement is in any degree actuated by malice. Malice is publication with the knowledge that the communication was false or with reckless disregard for whether it was false.

QUESTION NO. 10

Question No. 10(A) Defendant has the burden of proof on this question. With respect to each of the statements found by you in response to Question No. 7, do you find by the preponderance of the evidence that any of the Defendants had an interest or duty to another person having a corresponding interest or duty regarding the peer review action taken on May 14, 1998 or May 29, 1998?

Answer "Yes" or "No" as to each Defendant you answered "Yes" to in Question No. 4.

James Knochel, M.D.

ANSWER: No

Charles Levin, M.D.

ANSWER: No

John Harper, M.D.

ANSWER: No

Presbyterian Hospital

ANSWER: No

If you have answered "Yes" as to any Defendant in Question No. 10(A), proceed to answer Question No. 10(B) with respect to such Defendant(s). If you have answered "No" as to all of the Defendants in Question No. 10(A), proceed answer Question No. 11.

Question No. 10(B) Plaintiff has the burden of proof on this question. With respect to the statements identified by you in Question 10(A), do you find by a preponderance of the evidence that Defendants made such statements with malice?

James Knochel, M.D.

ANSWER: _____

Charles Levin, M.D.

ANSWER: _____

John Harper, M.D.

ANSWER: _____

Presbyterian Hospital

ANSWER: _____

If you have answered "Yes" as to any Defendant in Question No 10(B), proceed to answer Question No. 11 with respect to such Defendant(s). If you have answered "No" as to all of the Defendants in Question No. 10, proceed to the section entitled Business Disparagement and answer Question No. 12.

DEFAMATION DAMAGES

If you answered "Yes" to Question 9 as to any Defendant, then Dr. Poliner is presumed to have suffered general damages and you may estimate the amount of general damages without additional evidence. General damages may include injury to career and reputation and mental anguish. If you answered "No" to Question 9, then Dr. Poliner is not presumed to have suffered general damages, and you must assess what damages were proximately caused by such defamatory statements. In answering this question, you may only consider damages, if any, that resulted from the actions of Defendants occurring on or before May 14, 1998 and/or May 29, 1998. You may not, however, consider damages that stem from any action taken on or after June 12, 1998. Do not add any amount for interest on damages, if any.

"Proximate cause" means that cause which, in a natural and continuous sequence, produces an event, and without which cause such event would not have occurred. In order to be a proximate cause, the act or omission complained of must be such that a person using ordinary care would have foreseen that the event, or some similar event, might reasonably result therefrom. There may be more than one proximate cause of an event.

QUESTION NO. 11

What sum of money, if any, if paid now in cash, would fairly and reasonably compensate Dr. Poliner for his damages, if any, proximately caused by any such defamatory statements?

Consider the elements of damages listed below and none other. Consider each element separately and do not include damages for one element in any other element. Consider each Defendant separately and do not include damages as to one Defendant in assessing damages against any other Defendant.

Answer in dollars and cents as to each Defendant you answered "Yes" to in Question No. 4.

James Knochel, M.D.

loss of earnings
ANSWER: 10,526.55

injury to career and reputation
ANSWER: 20,000,000.00

mental anguish
ANSWER: 20,000,000.00

Charles Levin, M.D.

loss of earnings
ANSWER: 10,526.55

injury to career and reputation
ANSWER: 5,000,000.00

mental anguish
ANSWER: 5,000,000.00

John Harper, M.D.

loss of earnings
ANSWER: 10,526.55

injury to career and reputation
ANSWER: 5,000,000.00

mental anguish
ANSWER: 5,000,000.00

Presbyterian Hospital

loss of earnings
ANSWER: 10,526.55

injury to career and reputation
ANSWER: 15,000,000.00

mental anguish
ANSWER: 15,000,000.00

Proceed to the section entitled Business Disparagement and answer Question No. 12.

BUSINESS DISPARAGEMENT

Whereas, an action for defamation protects the personal reputation of nn injured person, an action for business disparagement protects the economic interests of the injured party against lost earnings. To recover on a claim of business disparagement, Lawrence Poliner, M.D., P.A. must pxove the following:

(1) that a Defendant published a false, disparaging statement;
(2) that the statement concerned the economic interests of Lawrence Poliner, M.D., P.A.; and

(3) that the statement was made with knowledge of the falsity of the disparaging statement or with reckless disregard concerning its falsity, or with spite, ill will, and evil motive, or intending to interfere in the economic interests of the Lawrence Poliner, M.D., P.A.

A statement is disparaging if it is understood to cast doubt upon the quality of another's land, chattels or intangible things, or upon the existence or extent of his or her property in them, and the publisher intends the statement to cast the doubt, or the recipient's understanding of it as casting the doubt was reasonable.

Reckless disregard means that a statement is made with a high degree of awareness of probable falsity.

A statement is published if it is communicated orally, in writing, or in print to some third person capable of understanding their defamatory import and in such a way that the third person did so understand. A defamatory statement can be published by conduct. A statement is published by conduct when the communication is made and understood without words. To be actionable in defamation, a statement must contain an assertion of an objectively verifiable fact Self-publication occurs when the plaintiff communicates a defamatory statement to a third party. An exception to the rule that the defendant must publish a statement exists when a reasonably prudent person would have expected that the plaintiff would communicate the defamatory statement to a third party.

Plaintiffs must establish lost earnings that have been realized, and the communication must play a substantial part in inducing others not to deal with Lawrence Poliner, M.D., P.A. with the result that special damage, in the form of lost earnings, is established.

QUESTION NO. 12

Did any of the Defendants with malice publish a disparaging statement regarding Lawrence Poliner, M.D., P.A.'s economic interests in connection with the suspension of Dr. Poliner's cardiac catheterization privileges on or before May 14, 1998 or May 29, 1998 that were false?

Answer "Yes" or "No" as to each Defendant you answered "Yes" to in Question No. 4.

James Knochel, M.D.

ANSWER: Yes

Charles Levin, M.D.

ANSWER: Yes

John Harper, M.D.

ANSWER: Yes

Presbyterian Hospital

ANSWER: Yes

If you have answered "Yes" as to any Defendant in Question No. 12, proceed to answer Question No. 13. If you have answered "No" as to all the Defendants listed in Question No. 12, proceed to the section entitled Interference with Contractual Relations and answer Question No. 14.

BUSINESS DISPARAGEMENT DAMAGES

In answering this question, you may only consider damages, if any, that resulted from the actions of Defendants occurring on or before May 14, 1998 and May 29, 1998. You may not, however, consider damages that stem from any action taken on or after June 12, 1998. Do not add any amount for interest on damages, if any.

QUESTION NO. 13

What sum of money, if any, if paid now in cash, would fairly and reasonably compensate Lawrence Poliner, M.D., P.A. for its damages, if any, that resulted from any such disparaging statements caused by Defendants?

Consider the elements of damages listed below and none other. Consider each element separately and do not include damages for one element in any other element. Consider each Defendant separately and do not include damages as to one Defendant in assessing damages against any other Defendant. Answer in dollars and cents for damages as to each Defendant you answered "Yes" to in Question No. 4.

James Knochel, M.D.

loss of earnings ANSWER: 1,000,000.00

Charles Levin, M.D.

loss of earnings ANSWER: 1,000,000.00

John Harper, M.D.

loss of earnings ANSWER: 1,000,000.00

Presbyterian Hospital

loss of earnings ANSWER: 1,000,000.00

Proceed to the section entitled Interference with Contractual Relations and answer Question No. 14.

INTERFERENCE WITH CONTRACTUAL RELATIONS

To recover for tortious interference with an existing contract, Plaintiffs must prove: (1) the existence of a contract subject to interference, (2) the act of interference was willful and intentional, (3) such intentional act was a proximate cause of Plaintiffs' damage and (4) actual damage or loss occurred.

Any such contract does not have to be in writing.

If the interference was merely an incidental result of conduct the Defendant(s) was engaging in for another purpose, the interference may be considered unintentional. "Proximate cause" means that cause which, in a natural and continuous sequence, produces an event, and without which cause such event would not have occurred. In order to be a proximate cause, the act or omission complained of must be such that a person using ordinary care would have foreseen that the event, or some similar event, might reasonably result therefrom. There may be more than one proximate cause of an event.

To recover for wrongful interference with prospective contracts, Plaintiffs must prove: (1) there was a reasonable probability that Plaintiffs would have entered into the contracts; (2) that Defendants intentionally prevented the contractual relations from occurring with the purpose of harming Plaintiffs; and (3) that Defendants conduct was independently tortious or wrongful.

Any such contract does not have to be in writing.

QUESTION NO. 14

As of May 14, 1998, did Plaintiffs have existing contracts with patients, health care plans, insurance companies, referral physicians, third party payors, hospitals other than Presbyterian Hospital, or medical instructions?

Answer "Yes" or "No".

ANSWER: Yes

If you have answered "Yes" to Question No. 14, proceed to the section entitled Intentional Infliction of Emotional Distress and answer Question No. 18. If you have answered "No" to Question No. 14, proceed to the section entitled Justification and answer Question No. 16.

QUESTION NO. 15

Do you find by a preponderance of the evidence that any of the Defendants intentionally interfered with Plaintiffs' existing and prospective contracts with patients, health care plans, insurance companies, referral physicians, third party payors, hospitals other than Presbyterian Hospital, or medical institutions?

Answer "Yes" or "No" as to each Defendant you answered "Yes" to in Question No. 4.

James Knochel, M.D.

Existing contracts ANSWER: Yes

Prospective contracts ANSWER: Yes

Charles Levin, M.D.

Existing contracts ANSWER: Yes

Prospective contracts ANSWER: Yes

John Harper, M.D.

Existing contracts ANSWER: Yes

Prospective contracts ANSWER: Yes

Presbyterian Hospital

Existing contracts ANSWER: Yes

Prospective contracts ANSWER: Yes

If you have answered "Yes" as to any Defendant in Question No. 15, proceed to answer Question No. 16. If you have answered "No" as to all Defendants in Question No. 15, proceed to the section entitled Intentional Infliction of Emotional Distress and answer Question No. 18.

JUSTIFICATION DEFENSE

A party is justified in interfering with another's contract if it exercises its own legal rights or a good faith claim to a colorable legal right, even though that claim ultimately proves to be mistaken. Defendants have the burden to prove that the interference was justified.

QUESTION NO. 16

Defendant has the burden of proof on this question. Did any of the Defendants interfere because they had a good-faith belief that they had a right to do so?

Answer "Yes" or "No" as to each Defendant you answered "Yes" to in Question No. 4.

James Knochel, M.D.

ANSWER: No

Charles Levin, M.D.

ANSWER: No

John Harper, M.D.

ANSWER: No

Presbyterian Hospital

ANSWER: No

If you have answered "Yes" to Question No. 16, proceed to the section entitled Intentional Infliction of Emotional Distress and answer Question No. 18. If you have answered "No" to Question No. 16, proceed to answer Question No. 17 only with respect to the Defendants to which you answered "No".

INTERFERENCE WITH CONTRACTUAL RELATIONS DAMAGES

Plaintiffs must show actual damage or loss was proximately caused by the alleged interference. "Proximate cause" means that cause which, in a natural and continuous sequence, produces an event, and without which cause such event would not have occurred. In order to be a proximate cause, the act or omission complained of must be such that a person using ordinary care would have foreseen that the event, or some similar event, might reasonably result therefrom. There may be more than one proximate cause of an event.

In answering this question, you may only consider damages, if any, proximately caused by the Defendants' interference occurring on or before May 14, 1998 and May 29, 1998. You may not, however, consider damages that stem from any action taken on or after June 12, 1998. Do not add any amount for interest on damages, if any.

QUESTION NO. 17

What sum of money, if any, if paid now in cash, would fairly and reasonably compensate Plaintiffs for their damages, if any, proximately caused by such interference?

Consider the elements of damages listed below and none other. Consider each element separately and do not include damages for one element in any other element. Consider each Defendant separately and do not include damages as to one Defendant in assessing damages against any other Defendant. Answer in dollars and cents for damages as to each Defendant you answered "Yes" to in Question No. 4.

James Knochel, M.D.

loss of earnings
ANSWER: 37,000.00

injury to career and reputation
ANSWER: 20,000,000.00

mental anguish
ANSWER: 20,000,000.00

Charles Levin, M.D.

loss of earnings
ANSWER: 37,000.00

injury to career and reputation
ANSWER: 5,000,000.00

mental anguish
ANSWER: 5,000,000.00

John Harper, M.D.

loss of earnings
ANSWER: 37,000.00

injury to career and reputation
ANSWER: 5,000,000.00

mental anguish
ANSWER: 5,000,000.00

Presbyterian Hospital

loss of earnings
ANSWER: 37,000.00

injury to career and reputation
ANSWER: 15,000,000.00

mental anguish
ANSWER: 15,000,000.00

Proceed to the section entitled Intentional Infliction of Emotional Distress and answer Question No. 18.

INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS

Intentional infliction of emotional distress occurs when a defendant acts intentionally or recklessly with extreme and outrageous conduct to cause the plaintiff emotional distress and the emotional distress suffered by the plaintiff was severe.

Conduct is intentional if the defendant desires to cause the consequences of his/its act or believes that the consequences are substantially certain to result from the act.

Conduct is reckless if the defendant knows or has reason to know of facts that create a high degree of risk of harm to another and deliberately proceeds to act in conscious disregard of or indifference to the risk.

"Extreme and outrageous conduct" occurs only where the conduct has been so outrageous in character, and so extreme in degree, as to go beyond all possible bounds of decency, and to be regarded as atrocious, and utterly intolerable in a civilized society.

QUESTION NO. 18

Did any of the Defendants intentionally inflict severe emotional distress on Dr. Poliner?

Answer "Yes" or "No" as to each Defendant you answered "Yes" to in Question No. 4.

James Knochel, M.D.

ANSWER: Yes

Charles Levin, M.D.

ANSWER: Yes

John Harper, M.D.

ANSWER: Yes

Presbyterian Hospital

ANSWER: Yes

If you have answered "Yes" to Question No. 18, proceed to answer Question No. 19. If you have answered "No" to Question No. 18, proceed to the section entitled Exemplary Damages and answer Question No. 20.

INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS DAMAGES

"Proximate cause" means that cause which, in a natural and continuous sequence, produces an event, and without which cause such event would not have occurred. In order to be a proximate cause, the act or omission complained of must be such that a person using ordinary care would have foreseen that the event, or some similar event, might reasonably result therefrom. There may be more than one proximate cause of an event.

In answering this question, you may only consider damages, if any, that resulted from the actions of Defendants occurring on or before May 14, 1998 and on May 29, 1998. You may not, however, consider damages that stem from any action taken on or after June 12, 1998. Do not add any amount for interest on damages, if any.

QUESTION NO. 19

What sum of money, if any, if paid now in cash, would fairly and reasonably compensate Dr. Poliner for his emotional distress, if any, proximately caused by Defendants?

Consider the elements of damages listed below and none other. Consider each element separately and do not include damages for one element in any other element. Consider each Defendant separately and do not include damages as to one Defendant in assessing damages against any other Defendant.

Answer in dollars and cents for damages as to each Defendant you answered "Yes" to in Question No. 4.

James Knochel, M.D.	
loss of earnings	ANSWER: 10,526.55
mental anguish	ANSWER: 20,000,000.00
Charles Levin, M.D.	
loss of earnings	ANSWER: -0-
mental anguish	ANSWER: 1,000,000.00
John Harper, M.D.	
loss of earnings	ANSWER: -0-
mental anguish	ANSWER: 1,000,000.00
Presbyterian Hospital	
loss of earnings	ANSWER: 10,526.55
mental anguish	ANSWER: 20,000,000.00

Proceed to the sectian entitled Exemplary Damages and answer Question No. 20.

EXEMPLARY DAMAGES

"Exemplary damages" means an amount that you may in your discretion award as a penalty or by way of punishment.

For purposes of this question only, "malice" means:

(a) a specific intent by any of the following to cause substantial injury to Dr. Poliner; or

(b) an act or omission by any of the following,

  (i) which, when viewed objectively from the standpoint of any of the following at the time of its occurrence, involved an extreme degree of risk, considering the probability and magnitude of the potential harm to others; and

  (ii) of which any of the following had actual, subjective awareness of the risk involved, but nevertheless proceeded with conscious indifference to the rights, safety, or welfare of others.

QUESTION NO. 20

Do you find by clear and convincing evidence that the harm caused by any of the Defendants resulted from malice?

Clear and convincing evidence requires a greater degree of persuasion than the preponderance of the evidence standard; however, proof to an absolute certainty is not required.

Answer "Yes" or "No" as to each Defendant you answered "Yes" to in Question No. 4.

James Knochel, M.D.

ANSWER: Yes

Charles Levin, M.D.

ANSWER: Yes

John Harper, M.D.

ANSWER: Yes

Presbyterian Hospital

ANSWER: Yes

If you have answered "Yes" as to any Defendant in Question 20, then answer Question No. 21. Otherwise, proceed to the last page entitled Certificate, sign the verdict form, and do not answer any further questions.

QUESTION NO. 21

In answering this question, you may only consider damages, if any, that resulted from the actions of Defendants occurring on or before May 14, 1998 and May 28, 1998. You may not, however, consider damages that stem from any action taken on or after June 12, 1998.

Factors to consider in awarding exemplary damages, if any, are –

a. The nature of the wrong.

b. The character of the conduct involved.

c. The degree of culpability of each Defendant.

d. The situation and sensibilities of the parties concerned.

e. The extent to which such conduct offends a public sense of justice and propriety.

f. The net worth of the Defendants.

Exemplary damages can be assessed against Presbyterian Hospital as a principal because of an agent by an agent, but only if:

a. Presbyterian authorized the doing and the manner of the act; or

b. the agent was unfit and Presbyterian was reckless in employing him; or

c. the agent was employed in a managerial capacity and was acting in the scope of employment with Presbyterian Hospital; or

d. Presbyterian Hospital or a manager of Presbyterian Hospital ratified or approved the act.

What sum of money, if any, if paid now in cash, should be assessed against any of the Defendants and awarded to Plaintiffs as exemplary damages, if any, for the conduct found in response to Question 20?

Consider each Defendant separately and do not include damages as to one Defendant in assessing damages against any other Defendant. Answer only as to the Defendants which you answered "Yes" to in Question 4.

James Knochel, M.D.	$40,000,000.00
Charles Levin, M.D.	$10,000,000.00
John Harper, M.D.	$10,000,000.00
Presbyterian Hospital	$50,000,000.00

CERTIFICATE

We, the jury, have answered the above and foregoing questions as herein indicated, and herewith return same into court as our verdict.

DATE: August 27, 2004

BY: /s/
PRESIDING OFFICER OF THE JURY

APPENDIX F

In the UNITED STATES COURT OF APPEALS for the Fifth Circuit

No. 06-11235

[Filed October 4, 2007]

Lawrence R. Poliner, MD;
Lawrence R. Poliner, MD, PA,

Plaintiffs-Appellees-Cross-Appellants,

v.

Texas Health Systems, a Texas
Non-Profit Corporation, doing
business as Presbyterian Hospital
of Dallas; James Knochel, MD,

Defendants-Appellants-Cross-Appellees.

Appeal from the United States District Court
for the Northern District of Texas
Honorable Jorge A. Solis,
United States District Judge

APPELLEES' BRIEF

Michael A. Logan
Karin M. Zaner
Kane, Russell, Coleman
& Logan, P.C.
3700 Thanksgiving Tower
1601 Elm Street
Dallas, Texas 75201
Telephone: 214-777-4200
Telecopier: 214-777-4299

Jeffrey S. Levinger
Thomas F. Allen, Jr.
Dustin B. Benham
Carrington, Coleman, Sloman
& Blumenthal, L.L.P.
901 Main Street, Suite 5500
Dallas, Texas 75202
Telephone: 214-855-3000
Telecopier: 214-855-1333

Attorneys for Appellees

CERTIFICATE OF INTERESTED PERSONS

No. 06-11235; *Lawrence R. Poliner, MD; Lawrence R. Poliner, MD, PA v. Texas Health Systems, a Texas Non-Profit Corporation, doing business as Presbyterian Hospital of Dallas; James Knochel, MD*

The undersigned counsel of record certifies that the following listed persons and entities as described in the fourth sentence of 5TH CIR. R. 28.2.1 have an interest in the outcome of this case. These representations are made in order that the judges of this Court may evaluate possible disqualification or recusal.

Plaintiffs-Appellees

Lawrence R. Poliner, MD
Lawrence R. Poliner, MD, PA

Counsel for Plaintiffs-Appellees

Michael A. Logan
Karin M. Zaner
Kane, Russell, Coleman
& Logan, P.C.
3700 Thanksgiving Tower
1601 Elm Street
Dallas, Texas 75201

Jeffrey S. Levinger
Thomas F. Allen, Jr.
Dustin B. Benham
Carrington, Coleman, Sloman
& Blumenthal, L.L.P.
901 Main Street,

Suite 5500
Dallas, Texas 75202

Defendants-Appellants

Texas Health Systems, a Texas Non-Profit Corporation, doing business as Presbyterian Hospital of Dallas
James Knochel, MD

Counsel for Defendants-Appellants

Thomas S. Leatherbury
Vinson & Elkins, L.L.P.
3700 Trammell Crow Center
2001 Ross Avenue
Dallas, Texas 75201

Lea F. Courington
Gwinn & Roby
4100 Renaissance Tower
1201 Elm Street
Dallas, Texas 75270

/s/
Jeffrey S. Levinger
Attorney of Record for
Plaintiffs-Appellees

STATEMENT REGARDING ORAL ARGUMENT

Appellees believe that oral argument may be useful in this case, but not for the reasons stated in Appellants' "statement regarding oral argument." Contrary to their characterizations (Br. at vii), the legal questions involved in this case are not especially "substantial," and the evidence, the verdict, and the numerous opinions below belie Appellants' one-sided version of the facts. This case turns more on the facts than the law. It involves a physician whose career and reputation were destroyed by a so-called "peer review" in which Appellants used the threat of an immediate suspension they knew they could not lawfully impose to coerce his "agreement" to an "abeyance" of his privileges. In so doing, Appellants permanently tarnished the physician's career and reputation, and succeeded in their goal of driving him out of the hospital. Given the volume of pleadings, the length of the trial record, and the detail of the trial court's opinions, oral argument is likely to aid the Court's decisional process.

TABLE OF CONTENTS

Certificate of Interested Persons i

Statement Regarding Oral Argument iii

Table of Contents iv

Table of Authorities vii

Statement of the Issues 1

Statement of the Case 2

Statement of Facts 5

Summary of the Argument 27

Argument 30

I. Standards of Review. 30

II. The Evidence Supports the Jury's Finding that Poliner Was Forced to Sign the May 14 and May 29 Abeyance Letters Under Duress. 31

III. The Evidence Supports the Jury's Findings that Defendants Are Not Entitled to Immunity. . . . 35

- A. The HCQIA Does Not Protect Defendants' Actions. 36
  - 1. Defendants had no reasonable belief that their actions furthered quality heath care. 38

2. Defendants made no reasonable effort to obtain the facts. 39

3. Defendants provided inadequate notice and hearing. 41

4. Defendants had no reasonable belief that their actions were warranted by the facts. 43

5. Defendants cannot resurrect immunity through the HCQIA's "emergency" provision. 45

B. The Texas Peer Review Statute Does Not Protect Defendants' Actions. 48

IV. The Evidence Supports the Jury's Findings that Defendants Defamed Poliner. 52

A. Defendants Published Statements that Were Defamatory *Per Se* and Were False. 52

B. Defendants' Defamation Was Not Qualifiedly Privileged. 57

C. The Defamation Claim Is Not Barred by Limitations. 58

V. Judgment Can Be Rendered on the Alternative Tort and Contract Claims. 59

A. The Evidence Supports the Jury's Findings of Tortious Interference. 60

B. The Evidence Supports the Jury's Findings of Breach of Contract. 63

C. The Tort Damages Were Caused by the May 1998 Actions. 65

VI. Defendants Are Not Entitled to a New Trial. . . 68

A. The Trial Court Correctly Determined that the Verdict Was Not the Product of Passion and Prejudice. 69

B. The Trial Court Correctly Exercised Its Discretion in Excluding the Hearing Committee's Endorsement of the June 1998 Suspension. 71

C. The Trial Court Correctly Exercised Its Discretion in Admitting Dr. Dunn's Testimony. 72

VII. Further Remittitur Is Not Necessary or Appropriate. 74

A. The Trial Court's Exercise of Discretion in Setting a Reduced Amount of Actual Damages Should Not be Second-Guessed. . 75

B. The Trial Court Correctly Determined that the Maximum Recovery Rule Does Not Apply Here. 79

C. The Evidence Supports the Separate Damage Awards Against the Hospital. 81

Conclusion 83

Certificate of Service 84

Certificate of Compliance With Rule 32(a) 85

TABLE OF AUTHORITIES

Cases

Accubanc Mortgage Corp. v. Drummonds, 938 S.W.2d 135 (Tex. App. -- Fort Worth 1996, writ denied) 55

Akin v. Santa Clara Land Co., 34 S.W.3d 334 (Tex. App. -- San Antonio, 2000, pet. denied) 59

American National Petroleum Co. v. Transcontinental Gas Pipe Line Corp., 798 S.W.2d 274 (Tex. 1990) 61

Beaumont v. Basham, 205 S.W.3d 608 (Tex. App. – Beaumont 2006, no pet.) 76

Bentley v. Bunton, 94 S.W.3d 561 (Tex. 2002) 49, 75, 76

Boczar v. Manatee Hospitals & Health Systems, Inc., 993 F.2d 1514 (11th Cir. 1993) 39

Boeing Co. v. Shipman, 411 F.2d 365 (5th Cir. 1969) (en banc) 30

Bressler v. Fortune Magazine, 971 F.2d 1226 (6th Cir. 1992) 74

Brown v. Parker Drilling Offshore Corp., 410 F.3d 166 (5th Cir. 2005) 71

Brown v. Presbyterian Healthcare Servs., 101 F.3d 1324 (10th Cir. 1996) . . . . passim

Browning-Ferris, Inc. v. Reyna, 852 S.W.2d 540 (Tex. App. -- San Antonio 1992), *rev'd on other grounds*, 865 S.W.2d 925 (Tex. 1993) 61

Brueggemeyer v. American Broadcasting Cos., Inc., 684 F. Supp. 452 (N.D. Tex. 1988) 73

Bryan v. James E. Holmes Reg'l Med. Ctr., 33 F.3d 1318 (11th Cir. 1994) 73

Caldarera v. Eastern Airlines, Inc., 705 F.2d 778 (5th Cir. 1983) 75

Cimino v. Raymark Indus., Inc., 151 F.3d 297 (5th Cir. 1998) 69

Coffey v. Singer Asset Finance Co., L.L.C., 223 S.W.3d 559 (Tex. App. -- Dallas 2007, no pet.) . 35

Colburn v. Bunge-Towing, Inc., 883 F.2d 372 (5th Cir. 1989) 70

Columbia Med. Ctr. of Las Colinas v. Bush, 122 S.W.3d 835 (Tex. App. -- Fort Worth 2003, pet. denied) 53

Copeland v. Alsobrook, 3 S.W.3d 598 (Tex. App. -- San Antonio 1999, pet. denied) 34

Dallas County Cmty. Coll. v. Bolton, 185 S.W.3d 868 (Tex. 2005) 32

Douglass v. Delta Air Lines, Inc., 897 F.2d 1336 (5th Cir. 1990) 80, 81

DSC Communications Corp. v. Next Level Communications, 107 F.3d 322 (5th Cir. 1997) 59

Duffy v. Leading Edge Products, Inc., 44 F.3d 308 (5th Cir. 1995) 49

Edwards v. Sears, Roebuck & Co., 512 F.2d 276 (5th Cir. 1975) 69

Evans v. Ford Motor Co., 484 F.3d 329 (5th Cir. 2007) 30

Flowers v. Southern Reg'l Physicians Servs., 247 F.3d 229 (5th Cir. 2001) 30

Frank B. Hall & Co. v. Buck, 678 S.W.2d 612 (Tex. App. --Houston [14th Dist.] 1984, writ ref'd n.r.e.) 50

Freedom Newspapers of Texas v. Cantu, 168 S.W.3d 847 (Tex. 2005) 73

Geosearch, Inc. v. Howell Petroleum Corp., 819 F.2d 521 (5th Cir. 1987) 63

Golden Bear Distrib. Sys. v. Chase Revel, Inc., 708 F.2d 944 (5th Cir. 1983) 53

Gonzalez v. San Jacinto Methodist Hosp., 880 S.W.2d 436 (Tex. App. -- Texarkana 1994, writ denied) 64

Gray v. Lynn, 6 F.3d 265 (5th Cir. 1993) . . 66, 71, 81

Hodges v. Mack Trucks, Inc., 474 F.3d 188 (5th Cir. 2006) 72

Huckabee v. Time Warner Entm't Co., 19 S.W.3d 413 (Tex. 2000) 58

Keipfer v. Beller, 944 F.2d 1213 (5th Cir. 1991) 60, 61

Knutson v. Morton Foods, Inc., 603 S.W.2d 805 (Tex. 1980) 82

Lane v. R.A. Sims, Jr., Inc., 241 F.3d 444 (5th Cir. 2001) 69

Marshall Field Stores, Inc. v. Gardner, 859 S.W.2d 391 (Tex. App. -- Houston [1st Dist.] 1993, writ dism'd w.o.j.) 55

Marvelli v. Alston, 100 S.W.3d 460 (Tex. App. -- Fort Worth 2003, pet. denied) 78

Moore v. Angela MV, 353 F.3d 376 (5th Cir. 2003) 80, 81

Pace Concerts, Inc. v. Smith, 990 F.2d 626, 1993 WL 117811 (5th Cir. 1993) (unpublished) 35

Parkway v. Woodruff, 901 S.W.2d 434 (Tex. 1995) . 78

Patel v. Midland Memorial Hospital & Medical Center, 298 F.3d 333 (5th Cir. 2002) 63

Payne v. Harris Methodist H.E.B., 2001 WL 252185 (N.D. Tex. Jan. 31, 2001) 46

Pipitone v. Biomatrix, Inc., 288 F.3d 239 (5th Cir. 2002) 74

Prudential Ins. Co. of Am. v. Financial Review Servs., Inc., 29 S.W.3d 74 (Tex. 2000) 63

Prunty v. Arkansas Freightways, Inc., 16 F.3d 649 (5th Cir. 1994) 82, 83

Pryor v. Trane Co., 138 F.3d 1024 (5th Cir. 1998) . 30

Purcell v. Seguin State Bank & Trust Co., 999 F.2d 950 (5th Cir. 1993) 56

Randall's Food Markets, Inc. v. Johnson, 891 S.W.2d 640 (Tex. 1995) 55

Rea v. Hospital Corp. of America, 892 F. Supp. 821 (N.D. Tex. 1994) 80

Reicheneder v. Skaggs Drug Ctr., 421 F.2d 307 (5th Cir. 1970) 55

Richardson-Eagle, Inc. v. William M. Mercer, Inc., 213 S.W.3d 469 (Tex. App. -- Houston [1st Dist.] 2006, no pet.) 62

Seidenstein v. National Med. Enterprises, Inc., 769 F.2d 1100 (5th Cir. 1985) 49

Seidman v. American Airlines, Inc., 923 F.2d 1134 (5th Cir. 1991) 75

Shell Offshore, Inc. v. Office of Workers' Comp. Programs, 122 F.3d 312 (5th Cir. 1997) 81

Shurtleff v. Giller, 527 S.W.2d 214 (Tex. Civ. App. – Waco 1975, no writ) 32, 34

Snyder v. Whittaker Corp., 839 F.2d 1085 (5th Cir. 1988) 74

Stable Energy, L.P. v. Newberry, 999 S.W.2d 538 (Tex. App. Austin 1999, pet. denied) 35

Stapleton v. Kawasaki Heavy Indus., Ltd., 608 F.2d 571 (5th Cir. 1979) 31, 76

State Nat'l Bank v. Farah Mfg. Co., 678 S.W2d 661(Tex. App. -- El Paso 1984, writ dism'd by agr.) 62

Stephan v. Baylor Med. Ctr., 20 S.W.3d 880 (Tex. App. – Dallas 2000, no writ) 64

Sugarbaker v. SSM Health Care, 190 F.3d 905 (8th Cir. 1999) 39

Suzuki Motor Corp. v. Consumers Union of U.S., 330 F.3d 1110 (9th Cir. 2003) 73

Texas Instruments, Inc. v. Teletron Energy Mgmt., Inc., 877 S.W.2d 276 (Tex. 1994) 65

Turner v. KTRK Television, Inc., 38 S.W.3d 103 (Tex. 2000) 53, 54, 55, 56

Van v. Anderson, 199 F. Supp.2d 550 (N.D. Tex. 2002) 64

Vogler v. Blackmore, 352 F.3d 150 (5th Cir. 2003) 81

Wal-Mart Stores, Inc. v. Sturges, 52 S.W.3d 711 (Tex. 2001) 62

Wells v. Dallas Indep. Sch. Dist., 793 F.2d 679 (5th Cir. 1984) 69

Wyler Indus. Works, Inc. v. Garcia, 999 S.W.2d 494 (Tex. App. -- El Paso 1999, no pet.) 78

Statutes

42 U.S.C. § 11112(a) 36, 45, 46

42 U.S.C. § 11112(a)(1) 38, 39

42 U.S.C. § 11112(a)(2) 40

42 U.S.C. § 11112(a)(3) 42, 43, 44, 46

42 U.S.C. § 11112(a)(4) 43, 44, 45, 48

42 U.S.C. § 11112(c)(1)(B) 41, 42

42 U.S.C. § 11112(c)(2) 37, 45, 46

42 U.S.C. § 11151(9) 37

TEX. OCC. CODE ANN. § 160.010(a)(2) 48

Rules

FED. R. CIV. P. 60(A) 63

FED. R. EVID. 401 71

FED. R. EVID. 403 71

FED. R. EVID. 704 73

Other Authorities

H.R.REP. No. 99-903, *reprinted in* 1986 U.S.C.C.A.N. 6384 46

RESTATEMENT (SECOND) OF TORTS § 774A(1)(c) (1977) 61

ABBREVIATIONS AND RECORD REFERENCES

Abbreviations

"The Hospital" refers to defendant Texas Health Systems, a Texas Non-Profit Corporation, d/b/a Presbyterian Hospital of Dallas.

"CIMA" refers to Cardiology and Internal Medicine Associates.

"CSANT" refers to Cardiothoracic Surgery Associates of North Texas.

"NTHC" refers to North Texas Heart Center.

"Defendants" refers collectively to the Hospital and James Knochel, MD.

"HCQIA" refers to the Health Care Quality Improvement Act, 42 U.S.C. § 11101, *et seq*.

Record References

Trial testimony and hearing testimony are denoted by a number, which refers to the volume of the Reporter's Record that the testimony appears in, followed by "RR" and a number, which refers to the page number appearing in the upper right hand corner of the page.

Pleadings, motions, and other court papers are denoted by "CR" followed by a number, which refers to the bates-stamp on the bottom right hand corner of the page. These documents were digitally imaged and filed on CD-ROM by the clerk.

Pleadings, motions, appendices, sealed filings, and other court papers that were not digitally imaged and are not included on the CD-ROM are denoted by "Doc.," which refers to the docket entry number listed on the trial court docket sheet appearing at CR0001, followed by a number, which refers to the document's own page number.

"PX" refers to the exhibits of plaintiffs Lawrence R. Poliner, MD and Lawrence Poliner, MD, PA.

"DX" refers to the exhibits of defendants Texas Health Systems, d/b/a Presbyterian Hospital of Dallas and James Knochel.

STATEMENT OF THE ISSUES

1. Was there sufficient evidence to support the jury's finding of duress, which was based on Defendants' threat of unlawful action to coerce Poliner into signing two abeyance letters that he had no obligation to accept? Further, can Defendants use the unpreserved and inapplicable defenses of estoppel and ratification to excuse their imposition of duress?

2. Was there sufficient evidence to support the jury's findings that Defendants' actions did not satisfy the requirements for HCQIA immunity?

3. Was there sufficient evidence to support the jury's findings that Defendants acted with actual malice and thus were not entitled to immunity under the Texas medical peer review statute?

4. Was there sufficient evidence to support the jury's findings that Defendants defamed Poliner, including by republishing defamatory *per se* statements within the limitations period?

5. Was there sufficient evidence that would support the rendition of judgment based on the jury's alternative findings of tortious interference and breach of contract?

6. Did the trial court correctly exercise its discretion in denying Defendants' motion for new trial, which erroneously contended that the damages verdict was the product of "passion and prejudice" and that certain evidence should have been admitted or excluded?

7. Should the trial court's exercise of discretion in ordering a substantial remittitur of the actual damages be left undisturbed, and did the trial court correctly reject Defendants' effort to compare the damages here to the different damages in an unrelated case in contravention of the "maximum recovery rule"?

STATEMENT OF THE CASE

Poliner and his professional association sued Knochel, the Hospital, and others for maliciously using a sham peer-review process to falsely label him as a dangerous doctor -- actions that Defendants knew would eliminate his solo cardiology practice at the Hospital and ruin his unblemished reputation. (CR0076) Poliner's suit, which asserted an antitrust claim and various state law causes of action, attacked primarily three actions by Defendants:

- Knochel's threat on May 14, 1998 to immediately suspend Poliner (an action reserved under the governing bylaws for physicians who constitute a present danger) if Poliner did not agree to an abeyance of his privileges in the catheterization lab (an action that could not be imposed under the bylaws without the physician's agreement).

- Knochel's threat on May 29, 1998 to immediately terminate Poliner without any opportunity for a hearing if Poliner did not agree to extend the abeyance to June 12.

- The decision to summarily suspend all of Poliner's privileges on June 12, 1998.

(CR0090-91, 0098-99, 2639-50, 3589)

After extensive discovery, Defendants moved for summary judgment claiming they were immune from damages under the federal HCQIA and the Texas medical peer review statute. (CR1337-1400) In response, Poliner presented extensive summary judgment evidence from twelve different experts that Defendants' actions were based on false and malicious criticisms of Poliner's work, were biased and pretextual, and were undertaken after woefully inadequate investigation, notice, and hearing. (Doc. 151 at 1-665) Despite this evidence, the trial court granted summary judgment in part on September 30, 2003, holding that the June 1998 suspension was entitled to statutory immunity. (CR2613, 2616, 2620) The court also dismissed Poliner's antitrust and DTPA claims (CR2600-05, 2623), but determined that fact issues existed as to whether the actions taken against Poliner on May 14 and May 29 were entitled to immunity (CR2607, 2611, 2619-21).[1]

Following a two-week trial that focused primarily on the May 14 and May 29 actions taken by Knochel, the Hospital, and two other defendant doctors, the jury unanimously found in Poliner's favor on every question submitted. (CR4443-91) Although the actual and exemplary damage figures in the verdict totaled over $366 million, Poliner recognized that the awards overlapped and thus sought actual damages of approximately $70 million and exemplary damages of $90 million against Knochel and the Hospital (the other two defendants having settled). (CR5373-74) Defendants filed extensive motions for JMOL and for new trial. (CR4859-4921, 5988-6078)

---

[1] Poliner filed a cross-appeal to preserve his right to challenge the adverse portions of the September 2003 order (CR7265-67), but has opted to omit those issues from this brief in order to streamline the appeal and limit consideration to the jury's verdict and the final judgment.

In a series of lengthy opinions and orders, the trial court ruled that: (1) Defendants had waived a number of their arguments by not raising them at trial; (2) the evidence supported the jury's findings that Defendants were not entitled to immunity;[2] (3) sufficient evidence supported the jury's findings of contract breach, defamation, and tortious interference, and judgment would be rendered on the defamation claim; (4) there was sufficient evidence that the damages awarded to Poliner resulted from the May actions (as opposed to the immune June action); (5) Defendants were not entitled to a new trial based on alleged trial errors or claims of jury passion and prejudice; (6) the awards of actual damages for injury to career/reputation and mental anguish were nonetheless excessive and should be remitted to a total of $21 million; and (7) exemplary damages should be statutorily capped at $750,000 against each Defendant. (CR6515-49, 6645-63, 7268-73, 6664-66, 7274-76) Poliner accepted the remittitur

---

[2] Defendants erroneously contend that the court based its immunity rulings on a finding that Defendants had breached the bylaws. (Br. at 6-7 & n.4) The court did not so rule, but as discussed further below, the bylaws are nevertheless relevant to the immunity analysis.

(CR6623-26), and the court rendered an amended final judgment consistent with its previous opinions (CR7274-76).

STATEMENT OF FACTS

Although Defendants pay lip service to the proper standard for reviewing jury verdicts (Br. at 27), they utterly ignore those standards in their recitation of the "facts." Instead of discussing the evidence in the light most favorable to the jury's verdict, Defendants have fashioned a sensationalized and one-sided version of the events -- scripted to create the impression that Poliner was a dangerous doctor whom Knochel dealt with fairly and reasonably by letting him agree to a short "Abeyance" of his cath lab privileges. The jury, however, unanimously rejected that misleading version of the story, and the evidence amply supported its findings. In fact, the evidence showed that Knochel used the threat of an immediate suspension of all of Poliner's privileges -- an action Knochel admitted he lacked any factual basis to take -- to coerce the "Abeyance" and falsely label Poliner as a dangerous doctor. This abuse of the peer-review process immediately and irreversibly destroyed the impeccable reputation and career that Poliner had built in over 20 years of practice. Thus, far from "gut[ting]" the HCQIA or the related Texas immunity statutes (Br. at 9), the judgment below simply confirms that to be immune, peer review must be honest and legitimate.

Poliner was and is a committed, dedicated, and skilled medical doctor. (CR6657-58) A specialist in interventional cardiology, Poliner graduated from Cornell Medical School in 1969 and completed his internship and residency at the University of Colorado in 1972. (PX-2; 5RR1114) After serving two years in the Air Force, he completed a cardiology fellowship at the University of Texas Southwestern Medical School in 1976, and then devoted nearly a decade to teaching cardiology at both Southwestern and Baylor University Medical School. (5RR1115, 1121, 1123-26; PX-2) He subsequently entered private practice, first joining a heart institute in Wichita, Kansas, and later working with a large cardiology group in Indiana that was developing new techniques. (5RR1128, 1190-91, 1196) Despite having performed thousands of diagnostic catheterizations and angioplasties during those years -- including high-risk procedures involving acutely-ill patients -- Poliner had never lost a patient in the cath lab, had never been sued for malpractice, and was uniformly acclaimed to be a good doctor. (5RR1126-27, 1194-95)

In 1996, a group known as CSANT recruited Poliner to move to Dallas and work at the Hospital. (5RR1196-98) He applied for privileges (PX 15), and after undergoing rigorous scrutiny, was appointed to the Hospital's medical staff and approved to perform cardiac catheterizations, angioplasties, and insertions of stents (2RR347-48; PX-33, 35). As a member of CSANT, Poliner did not directly compete with either of the two dominant cardiology groups at the Hospital -- NTHC or CIMA -- which drew patients primarily from the Dallas area. (5RR1198-99) Instead, he treated patients in outlying areas in northeast Texas and southern Oklahoma, and brought them to the Hospital only if they needed more extensive treatment in the cath lab. (5RR1198)

With only one exception, Poliner practiced without incident while he was associated with CSANT from June 1996 through May 1997. (5RR1199) The one exception involved Patient 10, an Oklahoma nurse who was sent to Poliner by her personal physician in November 1996 for a cardiac catheterization. (2RR353-54; 5RR1211-12; PX-501) Before the procedure, the patient said she was allergic to shellfish and Betadine. (5RR1212-13) Although these allergies do not indicate an allergy to the contrast dye used in catheterizations -- and Patient 10 did not reveal any such allergy -- Poliner offered to give her Benadryl as a preventative measure, which she refused. (3RR649, 672-78; 4RR899; 5RR1213-14) Poliner then proceeded with the catheterization, and although it was a complete success, Patient 10 later developed a rash that was promptly and effectively treated. (2RR359; 5RR1202-03; PX-52, 501) No one was able to say whether the rash was caused by the contrast dye. (6RR1377, 1415)

Nearly three months later, the Internal Medicine Advisory Committee ("IMAC") -- the peer-review body headed by Knochel, a Hospital employee and the chair of its internal medicine department (2RR293) -- reviewed the case of Patient 10 and asked Poliner to explain what had happened (5RR1200; DX-21). Poliner did so, and the IMAC cleared the case on March 10, 1997. (5RR1201-02; PX-52, 501) Knochel nonetheless contended that Poliner should not have gone forward with any procedure on Patient 10 once he learned she was allergic to anything (2RR356-58; 5RR1214-15; PX-53) -- ignoring the facts that the patient's physician had sent her to Poliner with acute coronary symptoms that needed prompt treatment and that the risk of allergic reactions to contrast dye was only four in one million (2RR352-53; 5RR1203, 1212-15). Further ignoring Patient 10's charts, Knochel falsely told Poliner that "there is no statement in the record explaining why a cardiac catheterization should have been performed." (2RR356; PX-53) According to Knochel, Poliner did not respond positively to these unfounded criticisms regarding Patient 10 (2RR356), and that response contributed to Knochel's opinion that Poliner was unfriendly, argumentative, disagreeable, and ungrateful (2RR366).

In June 1997, tired of the travel required by CSANT, Poliner and his wife decided that he should open his own solo practice at the Hospital. (5RR1208) This placed him in competition with the other cardiology groups there, including NTHC and CIMA. (1RR228-30; 4RR819-20; 5RR1209) Just as Poliner began to get his solo practice off the ground, however, Knochel and Dr. Charles Levin, the director of the cath lab and a member of CIMA, put up an unexpected road block. (4RR811-13, 822-23; PX-54) Even though Poliner had been credentialed to perform (and was performing) procedures in the Hospital's cath lab for many months while he was with CSANT (4RR826-28; PX-33, 35), Levin was told by either Knochel or the medical staff office that the documentation allowing Poliner to perform certain cath lab procedures was now inadequate, and he made Poliner cancel a scheduled procedure (4RR822-23). But Knochel and Levin could only temporarily disrupt Poliner's cath lab privileges. (4RR823) After the IMAC and Knochel reviewed Poliner's medical records and other data relating to his diagnostic and interventional procedures, even Knochel had to admit to Levin that "Dr. Poliner is qualified to perform these procedures." (4RR826-28; PX-54)

Over the following months, Poliner built his practice by obtaining referrals of acutely-ill coronary patients from the emergency room and directly from other physicians at the Hospital. (5RR1209, 6RR1277-78) By the fall of 1997, Poliner ranked fifth or sixth out of 20 doctors in the number of procedures performed in the cath lab. (7RR1661) This thriving practice placed him in serious competition with NTHC and CIMA, and produced friction with some cath lab nurses who were unaccustomed to the long hours he was working. (6RR1298-99; 9RR2147) Having previously been unable to eliminate Poliner's solo practice through pretextual "documentation" issues, Knochel, the Hospital, and Poliner's competitors instead launched a secret campaign, conducted entirely without Poliner's knowledge, to eliminate his privileges, ruin his practice, and destroy his reputation -- all under the guise of "peer review."

Between late September and mid-December 1997, three of Poliner's cath lab cases came under question. (2RR374, 418, 424)[3] In contrast to the give-and-take discussions involved in the review of Patient 10's case, the reviews of these three cases were performed entirely in secret -- so much so that Poliner was not even told the reviews were ongoing, much less consulted for his input. (6RR1299-1300) Had Poliner at least been consulted, he would have offered legitimate explanations for all of his actions, inactions, or decisions in treating all three acutely-ill patients. (6RR1304) Indeed, even the one-sided information Knochel and the Hospital developed gave them no basis for concluding -- as they ultimately did on May 13, 1998 -- that Poliner presented a danger to his patients and therefore needed to be immediately suspended. (2RR361-62, 449-50)

---

[3] Although Defendants now discuss a fourth case involving Poliner's treatment of Patient 39 in January 1998 (Br. at 13), Defendants conceded at trial that this case did not form the basis of their May 1998 actions toward Poliner that are at issue here (2RR373; PX-83). Moreover, far from being a "rookie mistake" -- as one of the former defendants in this case self-servingly described Poliner's insertion of a catheter through Patient 39's vein instead of an artery (3RR646) -- Poliner's cardiology experts testified that even experienced cardiologists occasionally enter a patient's vein instead of the artery (3RR702; 4RR922).

The first case at issue involved Patient 18, an 88-year old woman who died on September 28, 1997 while Poliner was performing an emergency catheterization in an effort to save her life. (4RR916; 6RR1264-67) Although Knochel (a nephrologist by training) believed that Poliner should not have performed the procedure at all (6RR1266), the facts belie that conclusion. Patient 18 was a heavy smoker with vascular disease, and was suffering an acute heart attack when she was admitted to the emergency room. (6RR1265, 1378-79) After Poliner informed Patient 18 of her options and the risks of a catheterization, she consented to the procedure. (6RR1265-66) The procedure turned out to be very complex as a result of her ongoing heart attack and calcified arteries, and she died from the heart attack Poliner was trying to treat -- not from the procedure itself. (6RR1385-86; 7RR1559-62)[4] Several months later, the Hospital's Mortality and Morbidity Review Committee analyzed the case and determined that it would not be referred for further review. (PX-68) Poliner firmly believed (and two cardiology experts later confirmed) that Patient 18 likely would have died had Poliner not performed the procedure. (4RR916; 6RR1265-66, 1378)

The second case involved Patient 9, an elderly man who suffered a stroke from bleeding in the brain the day after Poliner successfully reopened a heart-attack vessel on October 27, 1997. (2RR374; 5RR1215, 1226; PX-61) Knochel believed that the procedure itself "was fine," but that Poliner thereafter had abandoned the patient by not coming to the ICU in the middle of the night when the patient developed complications. (2RR376-77) The facts, however, portray a very different picture. Following the successful procedure, Poliner ordered a complete blood count within three hours -- a vital test for any coronary patient who has received blood thinning and anti-clotting medications. (6RR1242-44) But in this case, the Hospital staff delayed several hours in taking the blood count, and when Poliner later was informed that the patient's platelet count was abnormally low, he immediately stopped the medicines in order to reduce the risk of bleeding. (6RR1253-54)[5] At 2:30 a.m., a nurse called Poliner at home to report that the patient was slurring his speech. (6RR1257-58) Poliner correctly recognized that the patient was bleeding in the brain, and he ordered the nurse to immediately administer platelets to stop the bleeding. (6RR1258-59) Although Poliner, as a caring physician, wished in hindsight that he had personally come to the Hospital at 2:30 a.m. to be with his patient, he remained convinced (and a cardiology expert confirmed) that ordering platelets was "all that could be done" and that anything else he might have considered (like sending the patient for a diagnostic CT scan or to surgery) would have only endangered Patient 9 by moving him and causing more bleeding. (4RR909; 6RR1259-62, 1367-68) Indeed, it was not until the end of the next day that Patient 9 became stable enough for a neurosurgeon to successfully perform surgery. (2RR392; 3RR600; 6RR1263-64)

---

[4] Indeed, in a report Knochel requested, Dr. Charles Harris stated that "the catheterization and angioplasty were carried out in a satisfactory manner." (PX-88) Harris's report, however, made several misstatements about the timing of various events. (*Compare* PX-88 *with* 8RR1790-94)

The third case that Defendants seized upon involved Patient 3, a 74-year old acutely-ill man on whom Poliner performed a catheterization on December 16, 1997. (6RR1346) When the patient was later returned to the cath lab for an angioplasty, Poliner learned that the gauze dressing originally covering the sheath in the patient's groin area had become soiled with urine before the nurses had changed it. (5RR1171-72, 1177-78) Poliner examined the groin site, found no infection, exchanged the original sheath for a new one, and successfully performed the angioplasty. (2RR421; 5RR1168, 1173-74, 1178)[6] Although a nurse and a competitor of Poliner later took the position that Poliner should have used the other groin site for the angioplasty (2RR421-22; PX-75), Poliner had decided at the time not to do so because he needed to preserve that site in case he had to install a balloon pump (5RR1175-76). The balloon pump could "stay in the body for some days" and thus required "a fresh site" that "was clean and had been uncontaminated." (5RR1176) Two cardiology experts confirmed that Poliner's judgment was reasonable (4RR917-18; 6RR1347-52), and an advisory board at the Hospital ultimately cleared the case after determining that "there were no untoward effects" (PX-79; 6RR1274-75) -- thus corroborating Poliner's initial conclusion that there was no infection.

---

[5] Citing to a handwritten report of Dr. Charles Levin, Defendants now contend that Poliner "had given higher doses of blood thinning medication than recommended." (Br. at 12, citing PX-59) But three expert cardiologists dismissed that criticism, noting that the dosages Poliner gave were standard (or at least reasonable) at the time he performed the procedure in 1997. (3RR685-87; 4RR902-06; 6RR1357-62)

By May 1998, still unbeknownst to Poliner, the cases involving Patients 18, 9, and 3 had been under review for five months, and still no committee had found those cases to involve substandard care. (2RR374-75, 422; 6RR1272) Thus, the three cases did not provide Knochel and the Hospital any justification for impairing Poliner's privileges -- let alone taking the dramatic step of immediately suspending him.

---

[6] The initial reports of the Clinical Risk Review Committee inaccurately stated that Poliner had re-used the original sheath when he performed the angioplasty. (DX-23, 35) Dr. Rivera's handwritten review correctly stated that the sheath was exchanged but nonetheless made several erroneous assertions, including that the groin site was infected. (PX-75; 6RR1351)

(2RR374-75, 418, 423-25) On May 12, 1998, however, Defendants finally got the pretext they had been looking for following an event in the cath lab involving Poliner's treatment of Patient 36 -- an event that was first questioned by Levin, the director of the cath lab, a competitor at CIMA, and one of the persons who had unsuccessfully tried to disrupt Poliner's privileges the previous year. (4RR811; 6RR1298)

Patient 36 was a 46-year old male who was sent to the cath lab after treatment in the emergency room did not relieve his severe chest pain. (5RR1279; DX-179) Poliner correctly determined from the EKG and a catheterization that the undersurface of the patient's heart “was not moving normally” due to blockages in the right coronary artery (RCA); he also noted that there was disease in the left anterior descending artery (LAD) that supplied blood to the front of the heart, but correctly determined that this portion “was working well” because it was being supplied with blood by a collateral artery. (5RR1160-61, 1164; 6RR1284, 1395) Accordingly, Poliner worked on the patient's RCA and installed five stents -- a lengthy and complex procedure -- which immediately relieved the patient's chest pain. (6RR1279-80, 1286, 1395-96)

Despite the success of the procedure, Poliner learned later that day that he had missed a total occlusion in a part of the LAD. (6RR1298-99; DX-177) “Amazed and disconcerted” by this admitted mistake -- something he had never done in over 20 years of practice -- Poliner overreacted and hastily dictated an addendum to his initial report stating that if he had seen the occlusion in the LAD, he would have worked on it before the RCA. (5RR1163; DX-177) On deeper reflection, however, Poliner remained convinced (and three nationally-known cardiology experts later confirmed) that the RCA was the cause of the patient's problems, that even if Poliner had known of the LAD he would have been correct in repairing the RCA first, and that he in fact would have endangered the patient by starting with the LAD. (3RR708 [Wharton]; 4RR931-32 [Kern]; 5RR1160-64, 7RR1590 [Poliner]; 6RR1392 [DeMaio]) Indeed, although another cardiologist, Dr. Tony Das, had contemporaneously observed Poliner's work on Patient 36's RCA and noticed on the monitor that the LAD was occluded, Das said nothing to Poliner at the time because he felt that Poliner was not endangering the patient by fixing the RCA first. (2RR481-82)[7]

After the procedure, Poliner accompanied Patient 36 to an overflow ICU (opened specifically for that patient) where trained ICU nurses were to administer the red blood cells that Poliner had ordered and to monitor the sheath that was still in the patient's groin. (6RR1285-86; 9RR2040-41) Although Defendants' brief now attacks Poliner for his alleged "post-procedure neglect of Patient 36" (Br. at 17), that attack is irrelevant because Knochel was not aware of any such allegations at the time of his decisions about Poliner on May 13 (2RR428). In any event, the facts belie the allegation. Far from "fail[ing] to respond to numerous pages from nursing staff" (Br. at 15, 35), Poliner in fact personally saw the patient several times (9RR2042-43), and then "made multiple calls" to the ICU but could not get through on the telephone (7RR1665). Tied up in another procedure, Poliner sent his wife -- a nurse Ph.D. who worked in his office -- to the ICU to see Patient 36. (6RR1297; 7RR1665-66) There, Mrs. Poliner observed that Patient 36's head was significantly elevated (7RR1667-68) -- a position that can create bleeding problems at the site of the sheath in the groin (6RR1288-89). Indeed, around 2 or 3 p.m., Patient 36 began to experience breathing difficulties arising from excessive bleeding in his abdominal muscles. (9RR2020; DX-179) Dr. Selma Swafford, Patient 36's attending physician, promptly called in Dr. Kenney Weinmeister, a pulmonary and critical care specialist responsible for the care of ICU patients, to deal with the emergency. (9RR2018-20; DX-179) Weinmeister was able to stabilize Patient 36. (9RR2025)[8]

---

[7] Defendants' brief ignores all this testimony and instead relies extensively on the opinions of their own hired expert, Rick Lange, to support their claim that Poliner misdiagnosed the source of the patient's problems and therefore worked on the wrong artery. (Br. at 14, citing 8RR1760-65) But given the contrary testimony of Doctors Wharton, Kern, DeMaio, Poliner, and Das, the jury was entitled to discredit Lange's faulty opinions. In fact, Lange was forced to admit that Patient 36's LAD did not have to be repaired until three years later. (8RR1846)

Later that day, Levin told Poliner that he knew about the missed LAD "and that the case would have to be reviewed." (6RR1298) Levin, however, made no effort to obtain Poliner's explanation or to seek an outside review. (6RR1298-99; 8RR1774) Instead, Levin promptly reported the incident to Dr. John Harper, the chief of cardiology and a member of NTHC (4RR846), and Das reported it to Knochel on the morning of May 13 (2RR396-97). Knochel immediately took advantage of the opportunity -- with the Hospital's acquiescence -- to destroy Poliner's career and reputation.

---

[8] As they do with Lange, Defendants rely extensively on Weinmeister's testimony to create the false impression that Poliner's lack of responsiveness nearly allowed Patient 36 to die. (Br. at 15-16, citing 9RR2020-27) But the jury was entitled to discredit Weinmeister's undocumented opinions, especially given his admissions that he had no recollection of Patient 36 just a few weeks before the trial (9RR2032-33), and that he had never filed a written complaint about Poliner's care (9RR2051).

With nothing more to go on than incomplete reports regarding Patient 36, and the inconclusive but ongoing internal reviews concerning the long-ago completed treatment of Patients 18, 9, and 3, Knochel decided that Poliner's privileges in the cath lab should be placed in "abeyance" -- an action that could not be taken under the medical staff bylaws unless Poliner first agreed. (1RR189-91; 2RR256-57; PX-220 at 73) Although the bylaws further provided that a doctor who did not agree to an abeyance would be subjected to either "corrective action" or "suspension" (1RR189-91; PX-220 at 73), Knochel did not consider offering the option of "corrective action" to Poliner (2RR256-57, 364-65). That measure would have: (1) given Poliner an opportunity to interview with an investigating committee; (2) allowed for a variety of milder measures such as education, training, or the proctoring of his cases; and (3) required a full hearing under article IX of the bylaws before his privileges could actually be restricted or suspended. (6RR1447-48; PX-220 at 71-72, 76-79) Instead of corrective action, Knochel determined that the only other option he would offer Poliner would be the immediate suspension of all his privileges (2RR256-57, 364-65) -- a drastic step that the bylaws permitted *only* if the physician were so impaired or incompetent that he "constitute[d] a present danger to the health of his patients" (1RR206-07; PX-220 at 73).

Significantly, despite deciding on May 13 that suspension would be the only option for Poliner other than abeyance, Knochel did not have sufficient information to make the requisite finding that Poliner was a present danger to the health of his patients -- *and Knochel admitted as much at trial.* (2RR361-62, 449-50) The admitted lack of information, however, did not stop Knochel from presenting his two-option approach to the Hospital's president (Mark Merrill), its vice-president for medical staff affairs (Bruce Bougeno), and its in-house attorney (George Pearson). (2RR256-57, 402-06, 412; PX-80) Although Knochel claimed he "would have backed off" his decision if these Hospital employees had objected (2RR444), they did not object but in fact "acquiesced" and "agreed" to his plan (2RR403-04). Thus armed with "the sanction of the [H]ospital," Knochel summoned Poliner to a meeting at 5:00 p.m. on May 13. (2RR404; 6RR1299) Knochel told Poliner that Harper and Levin would be in attendance, but otherwise refused to tell Poliner what the meeting would be about. (6RR1299)

At the 5:00 p.m. meeting, Knochel told Poliner, in the presence of Harper and Levin, that Poliner had to sign a letter accepting an abeyance of his privileges to practice in the cath lab. (6RR1299-1300; PX-80) When Poliner asked why Knochel was making this request, Knochel refused to discuss any of Poliner's cases and did not let him provide any explanations. (6RR1300; 7RR1507; PX-80) Further, when Poliner asked what his options were, Knochel said that he could agree to the abeyance or else Knochel would terminate "all hospital privileges" and Poliner would be "off the staff" immediately. (2RR363-64; 6RR1300-01; 7RR1508; PX-80) Knochel did not mention the option of corrective action, he did not inform Poliner about his rights to a hearing, and he did not explain or provide a copy of the bylaws. (6RR1301) Poliner returned to his office feeling "scared," "devastated," and in "disbelief" of what Knochel had said. (6RR1301-02)

Around 3:00 p.m. on May 14, Knochel's assistant delivered to Poliner the letter requesting his agreement to the abeyance of his cath lab privileges. (6RR1302; PX-80, 83) The letter referred to Poliner's treatment of Patient 36 and informed him, for the first time, that his treatment of Patients 18, 9, and 3 was also currently under review. (PX-83) Poliner called Knochel and asked if he could have an attorney review the letter; Knochel replied that "he didn't have an attorney so [Poliner] couldn't have an attorney," and gave Poliner an immediate deadline to "[s]ign this letter right now and get it back down to the office or your privileges are gone." (2RR415-16; 6RR1302; 7RR1511-13) Based on Knochel's "ultimatum to do the abeyance or my privileges were finished," Poliner "was forced" to sign the letter and deliver it to Knochel. (6RR1302; 7RR1509) Knochel promptly sent a memo to six of the Hospital's cardiologists informing them that Poliner "has accepted abeyance" of his cath lab privileges, and appointing them to an ad hoc committee tasked with reviewing Poliner's cases during the preceding 18 months. (6RR1303; PX-82)

The news that Poliner had been banned from working in the cath lab, and the false statement that Poliner had agreed to the abeyance, quickly spread throughout the Hospital, and the consequences were immediate and devastating. (6RR1304-05, 1312) Before the abeyance that Knochel coerced, Poliner's reputation was impeccable, his patient and referral base was growing, and he was busy in the cath lab. (6RR1278, 1305) But immediately after the forced abeyance on May 14, Poliner's referral base from the other doctors "was gone. The phones stopped ringing. The practice was gone . . . I didn't have any patients after that. There were no referrals." (6RR1305, 1312) One of Poliner's key referral sources, Dr. Marty Cohen, confirmed that he had concerns about sending any of his patients to Poliner after hearing in May 1998 "that Doctor Poliner was having problems around the hospital." (3RR799-800, 803-05) Cohen's concerns were representative of those of any referral physician, who "would have to think at least five times before you would refer a patient" to a cardiologist whose privileges had been taken away. (6RR1342 [DeMaio])

When Poliner's referral sources told him that "my reputation was being destroyed," Poliner justifiably became concerned that he was being "labeled as a dangerous doctor" to whom "nobody would refer patients." (6RR1312) Poliner thus wrote a letter to Knochel on May 21 informing him "that there have already been some breaches of confidentiality of this matter" and warning that "[t]he rumors alone can have swift, direct and devastating economic effects on my reputation and practice that will be irreparable." (6RR1304; PX-87) When Knochel responded by asking Poliner to "describe the breeches [sic] of confidentiality" (PX-86), Poliner stated that he did not want "to involve my referral sources in this matter," but that those sources had expressed concern "that there should be a rapid resolution of this issue because it has been injurious to my reputation" (6RR1312; PX-90). The forced abeyance "devastated" Poliner and his family, "destroyed [his] life," damaged his health, and forever "affected his entire persona." (5RR1103; 6RR1301-02, 1311-12; 7RR1606, 1672, 1677-78)[9]

Still, Knochel and the Hospital were not through with Poliner. Instead of providing him the rapid resolution he so desperately needed; they opted to prolong their actions. On May 29, the last day of the 15-day period that the bylaws allowed for an abeyance (PX-220 at 73), Knochel wrote to Poliner seeking his acquiescence to a fourteen-day extension to June 12 (6RR1309-10; PX-92). Although Poliner by that time had contacted a lawyer named Chris Sharp, he had no opportunity to even consult with Sharp because Knochel again threatened to terminate all of Poliner's privileges with no opportunity to defend himself unless he signed the May 29 extension letter immediately. (6RR1310; 7RR1516-17, 1521) Recognizing that Knochel's threat would mean his "career was over,"

---

[9] Defendants try to downplay these injuries by noting that "Poliner maintained privileges at several other hospitals." (Br. at 22) But even though at least two other hospitals had granted limited privileges to Poliner, his practice was almost exclusively at the Hospital -- the location of his office, his staff, his referral base, and the cath lab. (6RR1305; 7RR1655-56, 1661-62) And significantly, Poliner would have had to tell these other hospitals about the actions Defendants took against him. (4RR1068; 6RR1345; PX-208)

Poliner had no choice but to sign the letter extending the abeyance to June 12. (6RR1310; PX-92)

During the 29-day abeyance period, Knochel and his hand-picked committee apparently reviewed 44 of Poliner's cases (PX-92), and reported their findings to the IMAC (Doc. 150 at p. 46). Poliner was given only one hour on June 11 to meet with the IMAC and explain the quality of his care. (Doc. 150 at p. 48) The next day, the IMAC made official what Knochel had twice threatened when it recommended that Knochel immediately suspend Poliner's catheterization privileges (and now his echocardiography privileges as well). (6RR1310) Convinced that he had rendered the best care possible for his critically-ill patients, Poliner requested a hearing, retained attorney Michael Logan, and asked several prominent cardiologists from around the country to review the medical records and opine about the quality of his care. (Doc. 150 at p. 58-59) In November 1998, following a three-day evidentiary hearing, a committee appointed by the Hospital's medical board recommended that Poliner's privileges be reinstated. (2RR368; 6RR1310-11)

Despite this reinstatement, Poliner's practice at the Hospital "was in fact ruined," and he was forced to move his office to Medical City Dallas and attempt to rebuild his practice there. (6RR1311-13, 1472) But even after moving, the damage to Poliner's career and reputation stemming from the forced abeyance and being falsely labeled a dangerous doctor persisted. Every time Poliner submitted an application to a hospital or HMO, he had to disclose (with appropriate explanations) that his privileges previously had been "restricted" as a result of the forced abeyance.

(4RR1066-68; 6RR1315-17, 1329-30, 1345-46; PX-207, 208) *In response to various requests for references,* Knochel also reported -- even as late as January 2000 -- that Poliner's privileges at the Hospital had been limited or restricted. (2RR439; 4RR1086; 7RR1638-39; PX-169, 171) The continuing adverse effects of the abeyance were consistent with the expectations of Poliner's peer-review expert that "to have this sort of thing happen would be an injury that would be irreparable, irreversible, and permanent, and that forever after Doctor Poliner's reputation as an invasive cardiologist would be in question because of what had happened." (4RR1016) Like a "surgeon who can't work in the operating room," an interventional cardiologist who loses the privilege to work in the cath lab -- even temporarily -- "is marked as a person who can't function in what he does." (4RR986-87)

To Poliner, the actions of Knochel and the Hospital meant that "all the things I worked for for many years over a long period of time in gaining experience in cardiology are just gone as a result of this." (6RR1327; *see also* 6RR1311-12) For his part, Knochel had no remorse or regret about what happened to Poliner, rationalizing his behavior with such denials as "I didn't do it. He did." (2RR443) Indeed, even though Poliner had not practiced at the Hospital for nearly four years by the time of trial in August 2004, Knochel still insisted that Poliner was a dangerous doctor who should not be practicing cardiology anywhere. (2RR349)

SUMMARY OF THE ARGUMENT

Defendants' entire brief rests on the false premise that Poliner, aided by the jury and the trial court, "recast" the "agreed Abeyance" as an "involuntary suspension," and then "leveraged" that "transformation" into a false and defamatory statement that Poliner was a dangerous doctor. (Br. at 24-25) This straw-man argument mischaracterizes the evidence. In fact, Knochel himself created that "transformation" by making two threats to immediately suspend or terminate Poliner (an action reserved under the bylaws for physicians who constitute a present danger) if Poliner did not "agree" to the abeyance (as the bylaws required). Knochel's threat of immediate suspension, however, was unlawful and malicious because he *knew* the facts did not support the requisite finding that Poliner was a danger. The "abeyance" was therefore coerced through duress, and without it the Defendants would not have been able to destroy Poliner's career and reputation. When the evidence is thus accurately characterized, Defendants' obstacles in overturning the jury's adverse findings and the court's substantially remitted judgment become insurmountable.

To begin with, there was ample evidence to support the jury's findings that the abeyance letters were obtained by duress -- specifically, Knochel's threat to do an act he had no legal right to do, in order to coerce Poliner's agreement to a damaging alternative Poliner had no legal obligation to accept. The evidence also supports the jury's findings that Defendants did not comply with *any* of the standards for HCQIA immunity, especially given their failure to provide

Poliner any opportunity for notice and hearing, and their admitted lack of belief that the immediate suspension Knochel threatened was warranted. For these and other reasons, Defendants also acted with the actual malice that prevents them from claiming immunity under the Texas peer review statute.

Defendants are also incorrect that the defamation verdict "rested on false premises and impermissibly stacked inferences." (Br. at 25) There was abundant evidence that Defendants -- through their threats, words, actions, and factual omissions -- published the false and defamatory message that Poliner not only was a dangerous doctor, but also admitted to being dangerous by "agreeing" to restrict his own privileges. The actual malice that accompanied Defendants' words and conduct is manifest. And the evidence amply supports the jury's verdicts on the alternative theories of contract breach and tortious interference with existing and prospective contracts, and the judgment below can be affirmed (in its entirety or as modified) based on any of those claims.

Finally, Defendants' shotgun-style requests for a new trial or further remittitur are as meritless as they are sparse. The trial court correctly found that the damage awards were not the product of "passion and prejudice," and it correctly exercised its discretion in admitting the testimony of Dr. Dunn and excluding one portion of an irrelevant and cumulative defense exhibit. And the court's substantial remittitur of the awards for mental anguish and loss of career/reputation should not be reduced any further, particularly given the overwhelming evidence of loss and the absence of any comparable case by which to apply the "maximum recovery rule."

ARGUMENT

I. Standards of Review.

Although Defendants attempt to minimize the effect of the applicable standards of review in this appeal (Br. at 27-28), those standards are highly deferential to the jury's verdict and the trial court's rulings. In attacking the sufficiency of the evidence supporting the verdict, Defendants face a daunting task because the Court's "standard of review with respect to a jury verdict is especially deferential." *Flowers v. Southern Reg'l Physicians Servs.*, 247 F.3d 229, 235 (5th Cir. 2001). Reviewing the record as a whole and drawing "all reasonable inferences most favorable to the [verdict]," the Court will affirm if there is "evidence of such quality and weight that reasonable and fair-minded [jurors] in the exercise of impartial judgment might reach difficult conclusions." *Boeing Co. v. Shipman*, 411 F.2d 365, 374-75 (5th Cir. 1969) (en banc). In conducting this review, the Court will "disregard all evidence favorable to the moving party that the jury is not required to believe." *Evans v. Ford Motor Co.*, 484 F.3d 329, 334 (5th Cir. 2007).

The denial of a motion for new trial based on the lower court's conduct of the trial (here, the admission or exclusion of evidence and the claim of alleged "passion and prejudice") is reviewed for abuse of discretion. *Pryor v. Trane Co.*, 138 F.3d 1024, 1026 (5th Cir. 1998). And where, as here, the trial court has already exercised its discretion and *granted* remittitur of a damages award, the scope of this Court's review is "even narrower than usual." *See, e.g.*, *Stapleton v. Kawasaki Heavy Indus., Inc.*, 608 F.2d 571, 574 n.7 (5th Cir. 1979). Thus, the standard Defendants cite for reviewing the *denial* of a motion for remittitur (Br. at 27-28) is inapplicable.

II. The Evidence Supports the Jury's Finding that Poliner Was Forced to Sign the May 14 and May 29 Abeyance Letters Under Duress.

Correctly recognizing that the so-called "Abeyance" could not be imposed under the bylaws unless Poliner first agreed to it (PX-220 at 73), the trial court instructed the jury in Question No. 2 -- with the parties' consent (10RR2291-92) -- to determine whether Poliner's alleged agreement to the May 14 and May 29 abeyance letters "was caused by duress, if any, imposed by the Defendants" (CR4451). In now attacking the jury's findings that "Poliner did not agree to the abeyance" on either date, Defendants misapply the law of duress to a self-serving and discredited version of the facts. Defendants then compound that error by invoking two purported defenses -- estoppel and ratification -- that were not preserved and, in any event, are inapplicable as a matter of law and fact.

In Texas, duress involves (1) "improper or unlawful conduct or threat of improper or unlawful conduct" (2) that "is intended to and does interfere with another person's exercise of free will and judgment." *Dallas County Cmty. Coll. v. Bolton*, 185 S.W.3d 868, 878-79 (Tex. 2005). The first element typically involves "a threat to do some act which the threatening party has no legal right to do." *Id.* at 879 (citation omitted). The second element occurs when the threatened act causes the party to whom it is directed "to do that which he would not otherwise do, and which he was not legally bound to do." *Shurtleff v. Giller*, 527 S.W.2d 214, 216 (Tex. Civ. App. -- Waco 1975, no writ). These principles expose the folly of Defendants' initial contention that Poliner merely faced "two options he did not like -- Abeyance and suspension." (Br. at 28)

The evidence is undisputed that on two separate occasions Knochel threatened to suspend or terminate all of Poliner's privileges immediately if he did not agree to two abeyances of his cath lab privileges. (2RR363-64; 6RR1301, 1310; 7RR1508, 1516-17; PX-80) It is also undisputed that Knochel had no legal right to carry out these threats because a suspension could be imposed under the bylaws only if the doctor "constitute[d] a present danger to the health of his patients" (PX-220 at 73), and Knochel admitted he lacked the factual basis to reach any such conclusion about Poliner (2RR361-62, 409, 449-50). And the evidence was overwhelming, if not undisputed, that those unlawful threats caused Poliner to act contrary to his free will by signing two letters that he would not otherwise have signed and that he was not legally bound to accept. (6RR1301-03, 1310; 7RR1515-17, 1523) Indeed, although Poliner had contacted a lawyer by May 29 (as Defendants point out), Knochel still was able to overcome Poliner's free will by again threatening to terminate all of his hospital privileges with no opportunity to defend himself unless he immediately signed the May 29 extension letter. (6RR1310; 7RR1516-17, 1521) These facts are entirely absent in the handful of duress cases Defendants now cite. (Br. at 28-29)

Defendants cannot overcome this evidence and the jury's findings by suggesting that Poliner was merely trying to "avoid [an] unfavorable alternative" and that he in fact "benefited from the Abeyance." (Br. at 29) These characterizations are at odds with the facts. The threatened suspension was an "alternative" Defendants had no legal right to impose and would have meant that Poliner's "career was over" (6RR1310), while the abeyance of his cath lab privileges was still a reputation-ruining event that Poliner was not legally bound to accept and was far worse than the unoffered alternatives of corrective action or an IMAC review (4RR986-89, 1013; 6RR1342-43). Nor can Defendants avoid the duress finding by arguing that "Poliner never informed [them] that he was secretly not agreeing to the Abeyance or that his agreement was withdrawn." (Br. at 29) A contemporaneous complaint about the coercive acts is not an element of duress, and the absence of such a complaint is not a defense to duress.[10] The jury here was entitled to conclude that any complaint by Poliner about coercion (or any attempt to withdraw the signed letters) would have only triggered the threatened suspension that caused Poliner's duress in the first place.[11]

---

[10] The one case Defendants cite to support their argument, *Copeland v. Alsobrook*, 3 S.W.3d 598 (Tex. App. -- San Antonio 1999, pet. denied), did not involve duress, and stands only for the inapposite proposition that the meeting of minds necessary to form a contract must be based on what the parties said and not on their subjective state of minds. *Id.* at 604.

[11] Defendants' observation that "Poliner maintained privileges at several other hospitals" (Br. at 30) is similarly irrelevant under the facts and the law. Poliner practiced almost exclusively at the

Finally, the doctrines of "estoppel" and "ratification" that Defendants attempt to invoke (Br. at 30-31) are both unpreserved and inapplicable. They are unpreserved because Defendants failed to include them in their initial motion for JMOL (CR4401-20) or to ask that they be submitted to the jury (Doc. 327, ex. I). The doctrines are also inapplicable as a matter of law and fact. As Defendants' own cases reveal, the doctrine of "estoppel by contract" simply does not apply when, as here, the contract on which the claim of estoppel is based was "void, annulled, or set aside in some way." *Coffey v. Singer Asset Finance Co., L.L.C.*, 223 S.W.3d 559, 569 (Tex. App. -- Dallas 2007, no pet.) (duress not at issue). This principle reflects the common-sense rationale that a party cannot be "estopped" from disavowing a contract that was procured in the first instance by duress. For the same reason, "equitable estoppel" cannot override the existence of duress, which was not at issue in the one estoppel case Defendants cite. *See Stable Energy, L.P. v. Newberry*, 999 S.W.2d 538, 547-48 (Tex. App. -- Austin 1999, pet. denied). And "ratification" will not arise if the threat giving rise to the duress continues in existence, as it indisputably did here when Knochel threatened Poliner with immediate suspension on both May 14 and May 29. *Cf. Pace Concerts, Inc. v. Smith*, 990 F.2d 626, 1993 WL 117811, at *4 (5th Cir. 1993) (unpublished) (contract was signed *after* threat giving

---

Hospital, and a suspension would have doomed his career no matter where else he held privileges. (6RR1310) Moreover, Texas courts have long held that the threat to terminate an employee unless he complies with the employer's demand will constitute duress, *see, e.g.*, *Shurtleff*, 527 S.W.2d at 216, even though the threatened employee could seek employment elsewhere.

rise to alleged duress had ceased to have any coercive effect).

III. The Evidence Supports the Jury's Findings that Defendants Are Not Entitled to Immunity.

The court below placed the burden on Poliner to overcome Defendants' claims for qualified immunity under both the HCQIA and the Texas peer review statute. (CR4450, 4454, 4458) The jury unanimously found that Poliner discharged his burden by proving that Defendants violated *every* requirement for immunity, and the evidence overwhelmingly supported its findings.

A. The HCQIA Does Not Protect Defendants' Actions.

Under the HCQIA, Poliner could rebut the statutory "presumption" of immunity by establishing that Defendants' "professional review actions" on May 14 and May 29 did not satisfy just *one* of the four requirements for immunity enumerated in 42 U.S.C. § 11112(a). *See Brown v. Presbyterian Healthcare Servs.*, 101 F.3d 1324, 1333 (10th Cir. 1996). Poliner more than met that burden by establishing -- as the jury found in response to Question No. 3 -- that Defendants' actions did not satisfy *any* of the four requirements. (CR4454-56) In now attacking these findings, Defendants and their amici set up an entirely false test -- one that assumes the professional review action to be evaluated under the HCQIA is merely an "Abeyance," voluntarily obtained and legitimately imposed. (Br. at 31-37) That argument ignores the evidence, the charge, the verdict, and the post-trial rulings below.

Contrary to the premise of Defendants' argument, the professional review action to be evaluated under the HCQIA requirements is not the "Abeyance" alone -- it is Knochel's decision to immediately suspend all of Poliner's privileges if he did not accept an abeyance of his cath lab privileges, and Knochel's threats on May 14 and May 29 to do just that unless Poliner promptly signed the abeyance letters. This broader view of the actions that must be evaluated under the HCQIA is compelled by the statutory definition of "professional review action," which includes any "action or recommendation . . . which is taken or made in the conduct of professional review activity . . . which affects (or may affect) adversely the clinical privileges . . . of the physician." 42 U.S.C. § 11151(9). Moreover, this broader evaluation of Defendants' actions is compelled by the court's charge, which defined "professional review actions" as "the suspension of Dr. Poliner's cardiac catheterization lab privileges on May 14, 1998 and May 29, 1998," and asked the jury to determine whether this "suspension" was undertaken in compliance with the HCQIA standards. (CR4452-54)

When the professional review action at issue is thus properly characterized, and when all the evidence is viewed in the light most favorable to the jury's answers to Question No. 3, there can be no question that Poliner rebutted all (and certainly at least one) of the four requirements for HCQIA immunity. And for similar reasons, Defendants cannot rely on the so-called "emergency" provision in § 11112(c)(2) to salvage their immunity claim. Indeed, given Defendants' extraordinary abuses of the peer-review process in this case, any other result would impermissibly transform the *qualified* immunity intended by Congress into *absolute* immunity. *See Brown*, 101 F.3d at 1334 n.9.

1. Defendants had no reasonable belief that their actions furthered quality heath care.

There was ample evidence to support the jury's findings in Question No. 3(1) that the actions taken against Poliner on May 14 and May 29 were not "in the furtherance of quality health care," and that Knochel and the Hospital could not have had a "reasonable belief" that they were. *See* 42 U.S.C. § 11112(a)(1). In each of the five medical cases Knochel and others criticized, the evidence demonstrated that if Poliner had actually administered the purported "care" demanded by the critics, he would have affirmatively *endangered* his patients. As the evidence showed, a reasonable person in Knochel's position would (or should) have known that:

- Patient 10 would have been placed in danger if Poliner had sent her back to Oklahoma without treatment merely to avoid the unlikely risk of a rash from her shellfish allergy. (2RR353-56; 5RR1211-12)

- Patient 18 likely would have died from her heart attack if Poliner had done nothing, instead of at least attempting cardiac intervention. (4RR916; 6RR1265-66)

- Patient 3 could have been harmed if Poliner had put the new sheath in the other groin and then later needed that groin site for a balloon pump. (5RR1175-76; 6RR1351-52)
- Patient 9 would have been endangered from further bleeding in the brain if Poliner had sent the patient off for a CT scan or to surgery in the middle of the night. (4RR909; 6RR1259-62, 1367-68)
- Patient 36 would have been placed at great risk if Poliner had worked first on the LAD instead of the RCA. (3RR708; 4RR931-32; 5RR1160-64; 6RR1392; 7RR1590)

Based on this evidence, the jury was entitled to conclude -- as it plainly did -- that Defendants were not operating under a reasonable belief that their actions were furthering *quality* health care. To the contrary, the evidence supported a finding that Defendants were trying to further an impermissible agenda that was entirely unrelated to health care. *See Boczar v. Manatee Hospitals & Health Systems, Inc.*, 993 F.2d 1514, 1518 (11th Cir. 1993) ("Fabricating damaging incidents or purposeful overreacting would be conduct that no reasonable medical practitioner or hospital could believe to be part of legitimate peer review."). Indeed, if Defendants had truly been interested in furthering the "objective medical concerns" required under § 11112(a)(1), *see Sugarbaker v. SSM Health Care*, 190 F.3d 905, 913 (8th Cir. 1999), they at least would have been willing to listen to Poliner's explanations regarding the care he administered.

2. Defendants made no reasonable effort to obtain the facts.

There was also abundant evidence supporting the jury's findings in Question No. 3(2) that the actions against Poliner on May 14 and May 29 were not taken "after a reasonable effort to obtain the facts of the matter." 42 U.S.C. § 11112(a)(2). Even though Knochel was prepared to suspend Poliner immediately on both dates (and used that threat to coerce an abeyance), neither he nor the Hospital had done any of the fact-gathering that a reasonable peer reviewer would ordinarily undertake before imposing such a drastic measure. Both Knochel and Merrill admitted that they did not have enough information to make the requisite finding that Poliner posed a present danger to his patients before deciding that he would be immediately suspended if he did not acquiesce in an abeyance. (1RR215; 2RR361-62, 449-50) Indeed, Knochel readily acknowledged that "files needed to be reviewed . . . people needed to be spoken to." (2RR409, 449)

Under § 11112(a)(2), however, those types of fact-gathering efforts should have been undertaken before, not after, Defendants decided that Poliner should be suspended. Instead, at the time Defendants decided Poliner's fate:

- the reviews of the cases involving Patients 3, 9, and 18 were still ongoing, and no one had even bothered to ask Poliner about these cases. (2RR422; 6RR1272)

- Knochel had not even looked at the files of Patient 9 despite claiming that this case was significant to his decision. (2RR373, 379)

- Knochel refused to hear Poliner's explanation of his treatment on Patient 36 and admitted that the case needed to be "investigated . . . more," despite claiming that this case was also significant to his decision. (2RR409, 413)

- Knochel failed to ask Das why he had allowed Poliner to continue working on Patient 36's RCA despite Das's contemporaneous observation that the LAD was occluded. (2RR397, 487-88)

- No one had reviewed the available database that would have revealed Poliner's consistently high level of patient care. (3RR546; 7RR1623)

Taken together, these omissions were more than sufficient for the jury to find that Defendants did not make "a reasonable effort to obtain the facts" before deciding that suspension was an appropriate remedy for Poliner. *See Brown*, 101 F.3d at 1334 (jury entitled to find that panel's review of only two charts before revoking physician's privileges was "unreasonably restrictive and not taken after a 'reasonable effort to obtain the facts.'").

3. Defendants provided inadequate notice and hearing.

Defendants initially are wrong in contending that "[n]otice and hearing were not required" for their actions against Poliner. (Br. at 35) The HCQIA provides that such procedures are not required for "a suspension or restriction of clinical privileges, for a period of *not longer than 14 days* . . . ." 42 U.S.C. § 11112(c)(1)(B) (emphasis added). This provision does not apply here because the initial suspension of Poliner began on May 14 and ended *fifteen days* later on May 29. (PX-82, 92) And while that period alone is sufficient to take Defendants' actions outside of § 11112(c)(1)(B), Defendants' demand that Poliner extend the suspension for an additional fourteen days to June 12 renders the provision's inapplicability even more obvious.

Defendants thus had to comply with the notice and hearing requirement under § 11112(a)(3), and ample evidence supported the jury's finding in Question No. 3(3) that their actions against Poliner were not undertaken "after adequate notice and hearing procedures" or "after such other procedures as are fair . . . under the circumstances." 42 U.S.C. § 11112(a)(3). Specifically:

- Knochel demanded that Poliner appear at the May 13 meeting but refused to tell him what the meeting would be about. (6RR1299-1300)

- At this meeting, Knochel refused to discuss any of Poliner's cases and did not let Poliner give any explanations. (6RR1300; 7RR1507)

- Harper and Levin also refused to let Poliner discuss his treatment of Patient 36. (3RR574-75, 651-52; 4RR847, 851)

- Knochel did not mention the option of corrective action, he did not inform Poliner about his rights to a hearing, and he did not explain or provide a copy of the bylaws. (6RR1301)

- Until May 14, Defendants did not tell Poliner that his treatment of Patients 3, 9, and 18 had even been under review. (PX-83; 6RR1299-1300)

- Knochel refused to let Poliner discuss or have an attorney review the May 14 letter (which Poliner received at 3:00 p.m.), and instead gave Poliner an immediate deadline to "[s]ign this letter right now and get it back down to the office or your privileges are gone." (2RR415-16; 6RR1302; 7RR1511-13)

- Defendants hindered Poliner's ability to review the charts from the four cases identified in the May 14 letter (PX-87) and refused to hear his viewpoint (2RR393, 413; 3RR651-52; 4RR851; 6RR1300).

- On May 29, when Knochel demanded that Poliner extend the abeyance period for an

> additional fourteen days, Knochel again threatened to terminate Poliner immediately and falsely stated that Poliner would have no opportunity to defend himself. (6RR1310; 7RR1516-17, 1521)

Multiple experts confirmed the obvious -- that Poliner received inadequate notice, was given no opportunity to be heard, and was the victim of a fundamentally unfair and unreasonable process. (3RR791; 4RR933-35, 992-94, 1015; 6RR1446-47) Accordingly, the evidence overwhelmingly established Defendants' violation of § 11112(a)(3).

4. Defendants had no reasonable belief that their actions were warranted by the facts.

Finally, ample evidence supported the jury's answer to Question No. 3(4) that Defendants' actions against Poliner were not undertaken "in the reasonable belief that the action was warranted by the facts known after such reasonable efforts to obtain facts and after meeting the requirement of [§ 11112(a)(3)]." 42 U.S.C. § 11112(a)(4). As demonstrated above, Defendants did not meet the requirement of § 11112(a)(3). They also did not have a "reasonable belief" on May 14 that the actions they took against Poliner were "warranted" by the known facts. Even though Knochel was prepared to suspend Poliner immediately -- and threatened just that -- both Knochel and Merrill admitted that they did not have enough information to make the requisite finding under the controlling bylaws that Poliner constituted a present danger to the health of his patients. (1RR206-07, 215; 2RR361-62, 449-50; PX-220 at 73) Knochel further acknowledged that he "probably [would] not" have suspended Poliner on May 14 on the basis of Patient 36 "[w]ith what I had in hand right on that day . . . until we investigated it more." (2RR409) By their own admissions, Defendants thus lacked *any* belief -- let alone the "reasonable belief" required by § 11112(a)(4) -- that the decision and threat to immediately suspend Poliner on May 14 were warranted by the known facts.[12]

Nor did Defendants have a reasonable belief on May 29 that immediately suspending all of Poliner's privileges was warranted by the known facts. Although Defendants now argue that by May 29 an ad hoc committee "had found a pattern of substandard care in over half of Poliner's cases" (Br. at 36), Defendants' only citation for that proposition is from the "background" section of the trial court's September 2003 summary judgment order (CR2596). In fact, there was no evidence at trial of the ad hoc committee's findings, Knochel's knowledge of any such findings, or even the notion that a claim of "substandard care" could warrant a finding that the doctor is a "present danger." To the contrary, the trial record was replete with evidence that Poliner was not a present danger, that no reasonable person could have believed that he was, and that a suspension thus was utterly unwarranted. (3RR673-74, 714-19; 4RR898, 933, 1015; 6RR1336, 1338-40, 1342, 1400) Poliner therefore disproved Defendants' compliance with § 11112(a)(4).

---

[12] Contrary to the suggestion of Defendants and their amici allies, this conclusion does not "confus[e] HCQIA immunity standards with language in the Medical Staff Bylaws." (Br. at 7 n.4) Rather, it merely evaluates the reasonableness of Defendants' actions (as required by the HCQIA) in light of Defendants' own standards for determining when such actions are warranted (as established by the bylaws).

5. Defendants cannot resurrect immunity through the HCQIA's "emergency" provision.

Having failed to satisfy any of the four requirements for immunity under § 11112(a), Defendants cannot resurrect their claim of immunity by invoking the HCQIA's so-called "emergency" provision, which allows "an immediate suspension or restriction of clinical privileges" if failing to do so "may result in an imminent danger to the health of any individual." 42 U.S.C. § 11112(c)(2). To begin with, § 11112(c)(2) is *not* -- contrary to the unsupported contention of Defendants and their amici -- "a second, independent provision which immunizes Defendants" even if they have failed to satisfy § 11112(a). (Br. at 36) Section 11112(c)(2) is merely an exception allowing the notice and hearing required under § 11112(a)(3) to be provided after the fact; it does not substitute for the other requirements of § 11112(a), including the need to have a reasonable belief that the action is warranted by the facts. *See* H.R.REP. NO. 99-903, *reprinted in* 1986 U.S.C.C.A.N. 6384, 6394 (describing emergency provision as an "exception[]" to "due process" that still requires a showing of "reasonable belief"); *Payne v. Harris Methodist H.E.B.*, 2001 WL 252185, at *3 (N.D. Tex. Jan. 31, 2001) (court analyzes all four requirements under § 11112(a); § 11112(c)(2) is relevant only to notice and hearing requirement).

In any event, regardless of whether § 11112(c)(2) is an exception to due process or a second basis for immunity, the evidence amply supported the jury's finding in Question No. 1 that Poliner did *not* pose "an imminent danger to the health of any individual" on either May 14 or May 29.[13] The HCQIA's emergency procedure is plainly intended for extraordinary cases in which a physician suddenly becomes impaired or grossly incompetent. The evidence here overwhelmingly disproved any such exigent circumstances. In the cases involving Patients 3, 9, and 18, Poliner's treatment had long since ended, reviews were still ongoing (although various committees had cleared cases 3 and 18), and no one had ever hinted that Poliner's work in the cath lab might pose an "imminent danger" to anyone. And while Poliner did miss part of an occluded LAD on Patient 36, he had never done that before in over 20 years of practice, Das was unconcerned when he contemporaneously observed Poliner's work on the RCA, and fixing the RCA immediately relieved the patient's symptoms. Based on Knochel's admission that he had not yet determined that Poliner posed a danger to his patients (2RR361-62, 449-50), and given the testimony from four experts that no one reasonably could have so determined (3RR673-64; 4RR1015; 6RR1338-39, 1340, 1342, 1400), the jury was more than entitled to reject the only contrary evidence that Defendants can now muster -- the discredited testimony of Weinmeister and the self-serving testimony of former defendants Levin and Harper (Br. at 37). *See Brown*, 101 F.3d at 1334 n.9 (noting jury's responsibility in HCQIA cases to weigh conflicting expert opinions).

---

[13] While Question No. 1 did not place the statutory word "may" before the "imminent danger" language (CR4450), the court's accompanying instruction precisely tracked the statutory language (CR4449: "Under the law, Defendants had the legal right to suspend or to threaten to suspend Dr. Poliner's privileges on May 14, 1998 and on May 29, 1998 if the failure to take such an action may have resulted in imminent danger to the health of any individual . . . ."). Defendants did not object to the question or the instruction, but in fact endorsed them. (10RR2244-45)

B. The Texas Peer Review Statute Does Not Protect Defendants' Actions.

After rejecting Defendants' claim of immunity under the HCQIA, the jury further found in Question No. 4 that Defendants were not entitled to immunity under the Texas peer review statute because they "took an action" against Poliner that was "with malice and not in the reasonable belief that the action was warranted by the facts known." (CR4458)[14] In attacking the finding of malice, Defendants again set up a false test to which they apply their own view of the evidence. Under the correct standard, the action that must be tested for malice is not a legitimately obtained and freely agreed "Abeyance"; it is Knochel's decision to immediately suspend Poliner if he did not accept an abeyance, and Knochel's threats to carry out that suspension unless Poliner promptly signed the abeyance letters. This characterization of the relevant actions is not, as Defendants describe it, a "litigation invention" involving a "transformation of the agreed Abeyance into an involuntary suspension." (Br. at 40 n.12) If any "transformation" occurred, it was caused by Knochel himself in coercing the abeyance through the only means he knew would be effective -- threatening to impose a suspension that he knew the facts did not warrant. That act alone demonstrates actual malice.

---

[14] Although Defendants now complain that the court's definition of actual malice in the instruction to Question No. 4 focused on "making a statement" rather than "taking an action" (Br. at 37 n.9), the former was consistent with the facts, and the question itself asked whether Defendants "took an action" with malice (CR4458). Contrary to Defendants' further complaint (Br. at 38 n.11), the court's additional requirement in Question No. 4 that Defendants have "a reasonable belief that the action was warranted by the facts known" comes directly from the statute, *see* TEX. OCC. CODE ANN. § 160.010(a)(2), and was disproved by the same evidence that disproved the identical requirement in 42 U.S.C. § 11112(a)(4).

As the trial court properly instructed the jury, actual malice exists when a statement is made with knowledge that it is false or with reckless disregard of whether it is false. (CR4457) Reckless disregard is a subjective standard that focuses on the conduct and state of mind of the defendant, *see Bentley v. Bunton*, 94 S.W.3d 561, 591 (Tex. 2001), and it occurs when the actor "entertain[s] serious doubts" or has a "subjective awareness of probable falsity." *Seidenstein v. National Med. Enterprises, Inc.*, 769 F.2d 1100, 1104 (5th Cir. 1985) (citations omitted). Because the actor's state of mind is at issue, actual malice "can -- indeed, must usually -- be proved by circumstantial evidence." *Bentley*, 94 S.W.3d at 596. Evidence that may support a finding of actual malice includes a "lack of care" or an "injurious motive" in making a statement, a statement "made on information that is obviously dubious," or "a purposeful avoidance of the truth." *Id.*; *see also Duffy v. Leading Edge Products, Inc.*, 44 F.3d 308, 315 n.10

(5th Cir. 1995) (inadequate investigation coupled with evidence of ulterior motive can establish actual malice). Thus, in *Frank B. Hall & Co. v. Buck*, 678 S.W.2d 612, 620-21 (Tex. App. -- Houston [14th Dist.] 1984, writ ref'd n.r.e.), evidence that the defendant's manager had a "strained" relationship with the plaintiff and "harbored animosity" toward him was sufficient to support the jury's finding that the statements at issue were made with actual malice.

Applying these principles under the proper standard of review, there is more than sufficient direct *and* circumstantial evidence to support the jury's findings that Knochel and the Hospital (both directly and through Knochel) acted with actual malice toward Poliner. Knochel had an intense dislike of Poliner (2RR366), and when Poliner began a solo practice in competition with the dominant cardiology groups at the Hospital, Knochel sided with those groups in trying to eliminate Poliner's privileges (1RR228-30; 2RR361-62; 4RR819-20; 5RR1209). When he failed to oust Poliner through the pretext of "inadequate documentation," Knochel authorized reviews of three cases in which the criticisms against Poliner were demonstrably exaggerated or manufactured. (*See* pp. 11-15, 38-39) Then, following the incident involving Patient 36, Knochel decided that Poliner would be immediately suspended -- an action reserved for only dangerous doctors -- if Poliner did not agree to put his cath lab privileges in abeyance. (2RR256-57, 364-65) But significantly, Knochel did not believe at the time that Poliner in fact constituted a present danger to his patients (2RR361-62, 365, 449-50), nor did he even profess to have such a belief. And the Hospital's president, Merrill, acquiesced in Knochel's decision even though he likewise lacked any basis to believe that Poliner posed a danger. (1RR215-17; 2RR403-04)

Although this evidence alone is sufficient to support the jury's finding of actual malice, other evidence corroborates that finding. By refusing to even listen to Poliner's explanation about any of the cases at issue -- despite acknowledging that "files needed to be reviewed" and "people needed to be spoken to" (2RR450) -- Knochel purposefully avoided facts that would have rebutted any claim that Poliner was a dangerous doctor. Further demonstrating his animosity and ulterior motive in trying to eliminate Poliner and injure Poliner's reputation, Knochel refused to let Poliner confer with a lawyer, failed to inform him of the less severe options (such as corrective action or IMAC review) that should have been available to him, and misleadingly told Poliner he could be terminated without any opportunity to defend himself. (*See* pp. 20-22, 24-25, 42-43) Based on this conduct, four experts on cardiology and peer review testified that no one could have taken these actions against Poliner except by knowingly or recklessly disregarding the truth about Poliner's medical care. (3RR714-19, 790; 4RR898, 933, 935, 1015; 6RR1338-40, 1342, 1400, 1440) This and other evidence amply supports the finding of actual malice, which prevents Defendants from claiming state-law immunity.

IV. The Evidence Supports the Jury's Findings that Defendants Defamed Poliner.

Starting with the unsupported assertion that the Hospital cannot be liable for damages because only Knochel "said anything about the Abeyance" (Br. at

40), Defendants' shotgun attack on the jury's defamation findings continues their pattern of misapplying the law to an erroneous view of the evidence. Defendants' initial proposition is wrong because the Hospital is vicariously liable for the defamatory statements of Knochel (a Hospital employee and a department chairman), which coupled with the Hospital's own acquiescence and ratification, support a separate award of damages against the Hospital. (*See* pp. 81-83) The remainder of Defendants' arguments -- relating to the concepts of publication, truth, privilege, and limitations -- are equally flawed.

A. Defendants Published Statements that Were Defamatory *Per Se* and Were False.

The evidence demonstrates that Defendants were responsible for publishing at least five categories of false and defamatory *per se* statements about Poliner. Any one of them supports the jury's answers to Question Nos. 7-9 and the judgment below.[15]

(1) On May 13, 1998, Knochel published a statement to Levin, Harper, Merrill, and several other

---

[15] Defendants' footnote contention that the court somehow "doom[ed]" the judgment by not submitting separate questions on each defamatory statement (Br. at 41 n.13) is wrong under Texas law. *See, e.g.*, *Columbia Med. Ctr. of Las Colinas v. Bush*, 122 S.W.3d 835, 859-60 (Tex. App. -- Fort Worth 2003, pet. denied). In any event, it was not preserved by a proper objection or requested question. (*See* 10RR2413: requesting only that jury be *instructed* about each defamatory statement, not that separate *questions* be submitted).

Hospital employees that Poliner's treatment of his patients would warrant his immediate suspension if he did not agree to an abeyance of his cath lab privileges. Because the bylaws allowed the immediate suspension of only those doctors who constituted a present danger to their patients, Knochel's statement conveyed the obvious and defamatory meaning that Poliner was a dangerous doctor. *See Turner v. KTRK Television, Inc.*, 38 S.W.3d 103, 114 (Tex. 2000) ("[A]n allegedly defamatory publication should be construed as a whole in light of the surrounding circumstances based upon how a person of ordinary intelligence would perceive it."); *Golden Bear Distrib. Sys. v. Chase Revel, Inc.*, 708 F.2d 944, 948-49 (5th Cir. 1983) (ordinary reader could interpret article to accuse plaintiff of fraud). Defendants failed to meet their burden of proving that this defamatory *per se* statement was true. Indeed, there was abundant evidence that Poliner was not a dangerous doctor, and at the time even Knochel did not believe that Poliner was dangerous. (2RR361-62, 449-50; 3RR673-64; 4RR935-36; 6RR1338-42)

(2) On May 14, 1998, Knochel sent a memo to six cardiologists at the Hospital stating that Poliner had "accepted abeyance" of his cath lab privileges. (PX-82) This statement was not "literally and substantially true," as Defendants conclusorily state. (Br. at 44) To the contrary, it was false because it failed to disclose that Knochel had coerced Poliner's alleged acceptance by threatening an immediate suspension that Knochel had no legal right to impose. *See Turner*, 38 S.W.3d at 114 ("[A] publication can convey a false and defamatory meaning by omitting or juxtaposing facts, even though all the [publication's] individual statements considered in isolation were literally true

or non-defamatory."). And the statement was defamatory *per se* because it conveyed the false and damaging meaning that Poliner had admitted his own deficiencies by volunteering to give up his cath lab privileges at least temporarily. *Id.* ("publication's meaning depends on its effect on an ordinary person's perception"). Nothing, of course, was further from the truth.

(3) Defendants' conduct of barring Poliner from the cath lab also constituted actionable defamation. As the trial court correctly instructed the jury, publication "by conduct" occurs when the communication to another "is made and understood without words." (CR4461) *See Reicheneder v. Skaggs Drug Ctr.*, 421 F.2d 307, 312 (5th Cir. 1970); *Marshall Field Stores, Inc. v. Gardner*, 859 S.W.2d 391, 396, 399 (Tex. App. -- Houston [1st Dist.] 1993, writ dism'd w.o.j.) (recognizing doctrine of "publication by conduct" but not applying it because jury charge was limited to "defamatory words").[16] Here, from the very moment

---

[16] Defendants acknowledged at trial that "conduct can constitute a defamation." (10RR2249) In now citing *Accubanc Mortgage Corp. v. Drummonds*, 938 S.W.2d 135, 150 (Tex. App. -- Fort Worth 1996, writ denied), for the proposition that "the very act of firing an employee" does not communicate the "words" required for defamation, Defendants ignore other Texas cases recognizing defamation by conduct. They also disregard the distinguishing fact in *Drummonds* that the employer never said anything about the reasons for the firing, which itself (unlike the suspension of a doctor) has no stated standards that would necessarily convey a defamatory meaning. *Id.* at 149. Equally inapposite is *Randall's Food Markets, Inc. v. Johnson*, 891 S.W.2d 640, 646 (Tex. 1995);

when Poliner was wrongly barred from the cath lab, the medical community understood that act to mean that Poliner had serious problems as a doctor. (3RR803-05; 6RR1309, 1312, 1344-45; PX-87, 90) Indeed, belying the fine distinction Defendants now try to draw between "the fact of Abeyance" and "suspension" (Br. at 43), two medical experts testified that physicians view these two rarely-imposed measures as "the same thing" -- namely, a statement that the affected doctor is a danger to his patients. (4RR1013-14; 6RR1344-45; *see also* 6RR1329-30) In Poliner's case, however, that statement was demonstrably false.

(4) In December 1999 and January 2000, long after Poliner's privileges were reinstated, Knochel responded to another hospital's inquiry about Poliner by twice reporting that Poliner's privileges had to be temporarily restricted. (2RR439; 4RR1086; 7RR1638-39; PX-169, 171) These statements conveyed a false meaning -- that Poliner was doing something seriously wrong -- by omitting to disclose material facts -- that the temporary restrictions had been coercively obtained and wrongfully imposed. *See Turner*, 38 S.W.3d at 114-15.

(5) In numerous applications to hospitals and HMOs, Poliner was repeatedly compelled to self-publish (with appropriate explanations) that his privileges had been "restricted" as a result of his forced

---

as the *Turner* court observed, the statements in *Randall's* presented a "true account of events" and involved no omission or misleading presentation. *Turner*, 38 S.W.3d at 115.

abeyance. (4RR1066-68; 6RR1313-17, 1324, 1329-30, 1345-46; PX-207, 208) Defendants knew or should have known that Poliner would have to do so. (2RR439-43) Contrary to Defendants' contention (Br. at 47 n.18), the jury was instructed to consider self-publication (CR4461), Poliner relied on self-publication in his post-verdict briefs (CR6122-24), and Texas courts recognize the doctrine. *See Purcell v. Seguin State Bank & Trust Co.*, 999 F.2d 950, 959 (5th Cir. 1993).

B. Defendants' Defamation Was Not Qualifiedly Privileged.

In response to Question No. 10(A), the jury rejected Defendants' claim of "qualified privilege" by finding that they did not communicate their defamatory statements to other persons "having a corresponding interest or duty regarding the peer review action taken" on May 14 or May 29. (CR4466) Even assuming that the six prospective ad hoc committee members to whom Knochel communicated on May 14 had the requisite "corresponding interest or duty," no one else did -- including Levin and Harper (who were not on any peer review committee), Poliner's referral sources at the Hospital, or the other hospital to which Knochel falsely reported long after the reinstatement of Poliner's privileges. Thus, Defendants failed to conclusively establish a qualified privilege.

In addition, although the jury did not have to answer Question No. 10(B) -- asking whether the privilege (if found) was lost because the defamatory statements were made with actual malice -- the jury did find actual malice in the materially identical

Question No. 4, and there was ample evidence to support its findings.[17] The entire act of barring Poliner from the cath lab, and every statement about that act, were actuated by actual malice. As discussed above, Defendants' words and acts labeled Poliner as a dangerous doctor, even though Defendants did not believe at the time that he in fact constituted a present danger. (*See* pp. 49-51, 53-56) Further, even though Knochel knew he had threatened Poliner with a suspension that he also knew lacked any factual basis, he failed to disclose these facts in his May 14 memo to create a false impression that Poliner had "accepted" an abeyance. *See Huckabee v. Time Warner Entm't Co.*, 19 S.W.3d 413, 426 (Tex. 2000) (knowing omission of a critical fact to create a false impression raises inference that defendant acted with actual malice). And Knochel again acted with actual malice in December 1999 and January 2000, when he failed to disclose that the restriction on Poliner's privileges initially had been coerced and later had been eliminated. This evidence fully supports the finding of actual malice.

C. The Defamation Claim Is Not Barred by Limitations.

Defendants' seven-sentence argument about the statute of limitations ignores the trial court's three opinions thoroughly analyzing and then rejecting that defense. (CR2621, 6540-44, 7269-70) As the court correctly held, Defendants republished the defamatory statements in December 1999 and January 2000 (shortly before Poliner filed suit on May 11, 2000), and thus limitations does not bar Poliner's defamation claim. (*Id.*) Further, these republications are actionable, and they plainly referred to the unlawful restrictions in May 1998 rather than the allegedly immune restriction in June 1998. (4RR1086-87; PX-169, 171) In any event, as the court below correctly held, Defendants waived any arguments to the contrary by not timely raising them. (CR6541-44, 7269-70)[18]

---

[17] Other than their own *ipse dixit* (Br. at 45 n.17), Defendants offer no legal or logical reason why the jury's finding of actual malice in Question No. 4 would have to be repeated in the answer to Question No. 10(B) to overcome the defamation qualified privilege, just as it overcame the Texas peer review immunity.

V. Judgment Can Be Rendered on the Alternative Tort and Contract Claims.

Although the judgment below should be affirmed based on the defamation verdict, it also can be upheld on the alternative verdicts for tortious interference and breach of contract. *See DSC Communications Corp. v. Next Level Communications*, 107 F.3d 322, 327 (5th Cir. 1997) (affirming judgment on alternative verdict for misappropriation even though judgment based on usurpation verdict was vacated).[19]

---

[18] There is also no merit to Defendants' cursory footnote argument that Poliner cannot recover damages from the 1998 defamation by proving republication within the limitations period. The one case they cite for that proposition, *Akin v. Santa Clara Land Co.*, 34 S.W.3d 334, 340-41 (Tex. App. -- San Antonio, 2000, pet. denied), says nothing about the recoverability of damages when, as here, limitations has been defeated by actionable republications. The rule Defendants propose also makes no sense when, as here, the republished statements relate directly back to the 1998 statements and the resulting damages are continuing, intangible, and not susceptible to precise temporal apportionment.

A. The Evidence Supports the Jury's Findings of Tortious Interference.

In response to Question Nos. 14-17, the jury found that Defendants interfered with Poliner's contractual relationships (both existing and prospective), that the interference was not justified, and that Poliner was entitled to damages of the same type and amounts as the defamation damages. (CR4475-82) As the trial court found, sufficient evidence supported these findings, and thus the tortious interference claim constitutes an alternative basis for affirming the judgment. (CR6544-47)

Under *Keipfer v. Beller*, 944 F.2d 1213 (5th Cir. 1991) -- which Poliner and the trial court cited but which Defendants ignore -- there is ample evidence to support the findings that Defendants tortiously interfered with Poliner's practice. Like the doctor in *Keipfer*, *id.* at 1220, Poliner enjoyed a thriving practice that grew from physician and patient referrals. (6RR1277-78, 1305; 7RR1661) But Defendants intentionally destroyed that practice and Poliner's reputation by forcing Poliner to agree to the "abeyance" under duress, unjustifiably barring him from the cath lab, and publishing the false statement that he was a dangerous doctor. (*See* pp. 22-27, 76-78) These acts interfered with Poliner's relationships with his referral sources, other hospitals, and health plans, and as a direct result, Poliner's reputation was ruined and he suffered significant mental anguish. (4RR1068-69; *see* pp. 22-27, 78-79) This evidence closely mirrors the facts in *Keipfer* and fully supports the jury's findings of liability for tortious interference and its damage awards for injury to career and reputation and for mental anguish (as reduced by the trial court). *Keipfer*, 944 F.2d at 1220.[20]

---

[19] Because the court below did not address the additional verdicts for business disparagement and intentional infliction of emotional distress, Poliner does not rely on them here.

Defendants are also incorrect that the claim of tortious interference required Poliner to specifically identify "patients whose procedures had to be rescheduled or who fired Poliner." (Br. at 48) Rather, as this Court recognized in *Keipfer*, an interference with a doctor's general referral practice is sufficient to support a claim for tortious interference with prospective contracts. *Keipfer*, 944 F.2d at 1220; *see also Richardson-Eagle, Inc. v. William M. Mercer, Inc.*, 213 S.W.3d 469, 476 (Tex. App. -- Houston [1st Dist.] 2006, no pet.) (tortious interference with prospective contractual or business relations requires proof only that the contracts or relations be "reasonably probable" under the circumstances).

---

[20] Contrary to Defendants' contention (Br. at 59 n.27), damages for injury to career/reputation, as well as damages for mental anguish, are recoverable in Texas under a claim of tortious interference, just as they are recoverable under defamation. *See, e.g.*, *Browning-Ferris, Inc. v. Reyna*, 852 S.W.2d 540, 549 (Tex. App. -- San Antonio 1992) (listing "emotional distress or actual harm to reputation" among damages available for tortious interference) (citing RESTATEMENT (SECOND) OF TORTS §744A(1)(c) (1977), *rev'd on other grounds*, 865 S.W.2d 925 (Tex. 1993). The one case Defendants cite, *American National Petroleum Co. v. Transcontinental Gas Pipe Line Corp.*, 798 S.W.2d 274, 278 (Tex. 1990), does not discuss these damages.

Nor is there any merit to Defendants' premise that the tortious interference claim rests solely on defamation. (Br. at 48) For tortious interference with prospective contracts, a plaintiff need only prove an independently tortious or wrongful act. *Wal-Mart Stores, Inc. v. Sturges*, 52 S.W.3d 711, 726 (Tex. 2001). In addition to Defendants' defamatory conduct, Defendants' coercive conduct in obtaining Poliner's agreement to the abeyance through duress satisfies this element because duress is both wrongful and an actionable tort. *See, e.g., State Nat'l Bank v. Farah Mfg. Co.*, 678 S.W2d 661, 683 (Tex. App. -- El Paso 1984, writ dism'd by agr.). Thus, the tortious interference claim is not grounded exclusively in defamation.

Finally, as the trial court held, Defendants waived their defense of justification (CR6546 n.10) and, in any event, they failed to establish it (CR4479). With regard to interference with prospective contracts, justification is a defense "only to the extent" it is a defense to "the independent tortiousness of the defendant's conduct." *Sturges*, 52 S.W.3d at 727. Because there is no justification defense to duress (or defamation), this potential defense to an interference claim is unavailable to Defendants as a matter of law. *See id.*; *Prudential Ins. Co. of Am. v. Financial Review Servs., Inc.*, 29 S.W.3d 74, 81 (Tex. 2000). Further, Defendants had no legal right to, or good-faith belief that they could, interfere with Poliner's existing contracts by securing the abeyance of Poliner's privileges through the unlawful threat of suspension.[21]

B. The Evidence Supports the Jury's Findings of Breach of Contract.

Alternatively, the Court may affirm the judgment as modified based on the breach of contract claim by Poliner's professional association. As a preliminary matter, Defendants are wrong in suggesting that the trial court could not correct the unobjected-to omission of the P.A. from the breach of contract damages question. (Br. at 49) Even the case Defendants cite, *Geosearch, Inc. v. Howell Petroleum Corp.*, 819 F.2d 521 (5th Cir. 1987), notes that a trial court "may correct clerical errors in a verdict," which is all the court did here. *Id.* at 527 (citing FED. R. CIV. P. 60(a)). (CR6533)

Defendants are also incorrect that the evidence does not support this claim. As the trial court correctly ruled (CR2605-07, 6528-29), section 11.04 of the Hospital bylaws creates an enforceable contract with physicians by incorporating the medical staff bylaws' procedural due process requirements for restricting physician privileges.[22] Because the Hospital bylaws thus provide the means by which the Hospital may curtail physician privileges, and impose an affirmative duty of compliance on the Hospital, they constitute an enforceable contract. *Gonzalez v. San Jacinto Methodist Hosp.*, 880 S.W.2d 436, 438-39 (Tex. App. -- Texarkana 1994, writ denied).

---

[21] This stands in stark contrast to *Patel v. Midland Memorial Hospital & Medical Center*, 298 F.3d 333, 347 (5th Cir. 2002), cited by Defendants (Br. at 48-49), where the defendants' interference with the plaintiff-physician's business relationships was justified because it was undertaken under a peer-review process involving careful investigation and unmarked by any acts of coercion or duress.

Sufficient evidence also supports the jury's findings that the Hospital breached its contract:

- In response to Question No. 1, the jury found that Defendants lacked a reasonable belief that Poliner posed a "present danger" to his patients. By allowing Poliner to be threatened with summary suspension without this reasonable belief, the Hospital breached Art. VIII--Part C: § 3(a) of the medical staff bylaws, as incorporated into the Hospital's bylaws.

- In response to Question No. 2, the jury found that Defendants obtained the abeyances by duress. In so doing, the Hospital breached Art. VIII--Part C: § 2(a) of the medical staff bylaws, which permits the Hospital to abate privileges only if the physician agrees.

---

[22] Specifically, section 11.04 provides that "[t]he Medical/Dental Staffs' Bylaws shall provide a process for denying, withdrawing or qualifying staff privileges, which provides procedural due process for the member." (PX-223 at 13) By contrast, the hospital bylaws in the cases Defendants cite had no such provision. *Stephan v. Baylor Med. Ctr.*, 20 S.W.3d 880, 887-88 (Tex. App. -- Dallas 2000, no writ); *Van v. Anderson*, 199 F. Supp.2d 550, 562-63 (N.D. Tex. 2002).

- In response to Question No. 3(3), the jury found that Defendants failed to provide adequate notice and hearing, thus violating section 11.04 of the Hospital's bylaws.

Finally, Ruth Poliner's testimony regarding the P.A.'s lost earnings was sufficient to support an award of $10,526.55. Mrs. Poliner described the data she relied on and the method she used to calculate that figure -- and the Hospital objected to neither. (11RR2460-66) This competent evidence, based on objective facts and data, was sufficient to establish the P.A.'s lost earnings with "reasonable certainty." *Texas Instruments, Inc. v. Teletron Energy Mgmt., Inc.*, 877 S.W.2d 276, 278-79 (Tex. 1994). And an award of the requested $1,902,371.68 in attorney's fees is similarly allowed under the law and the supporting proof. (CR4652-74)

C. The Tort Damages Were Caused by the May 1998 Actions.

Defendants end their discussion of Poliner's other causes of action by switching gears and asserting that Poliner did not introduce evidence of damages that were "caused exclusively" by their May 1998 actions, as opposed to their June 1998 actions (which were found to be immune). (Br. at 53-54) This argument disregards the jury charge, the evidence, and basic principles of tort causation.

To begin with, the trial court instructed the jury to consider only those damages that resulted from the actions in May 1998, and not from any action on or after June 12, 1998. (CR4460, 4462, 4469, 4474, 4480, 4485) The court also noted, however, that it did *not* instruct the jury "that the scope or extent of Plaintiffs' injury and/or damages must be limited to a particular time period." (CR6547-48) Because "juries are presumed to follow their instructions" and Defendants have offered "no valid basis for disregarding that established presumption," the Court should reject Defendants' invitation to assume that the jury awarded damages that resulted from the June suspension rather than the May forced abeyances. *Gray v. Lynn*, 6 F.3d 265, 271 (5th Cir. 1993) (citations omitted).

Moreover, the evidence demonstrated that Poliner's tort damages (mental anguish and injury to career/reputation) began immediately after the forced abeyance of May 14. (6RR1301-02, 1311-12; *see* pp. 22-24) Poliner learned from other physicians "at the very onset" that his reputation "was being destroyed." (6RR1312) Consequently, his referrals stopped immediately (6RR1305) and his practice was already "gone" (6RR1311). Indeed, the very next day after the May 14 forced abeyance, Poliner received a phone call from Dr. Marty Cohen, one of his referring physicians, who had learned of the abeyance; thereafter, Cohen stopped referring patients to Poliner. (3RR803-05; CR6540)[23]

---

[23] That the cessation of Dr. Cohen's referrals did not begin until June 1998 does not mean, as Defendants suggest (Br. at 23), that

Largely disregarding this evidence, Defendants instead contend that any damages Poliner sustained after June 1998 could not have been attributable "exclusively" to the May 1998 actions and thus cannot satisfy the causation element. (Br. at 22-23, 53-54) This argument has two fundamental defects. First, there is no requirement that the May actions have been the "exclusive" cause of Poliner's damages; as the trial court correctly instructed the jury, there can be more than one proximate cause of an event. (CR4468, 4480) Defendants themselves acknowledge that the May actions need only have been a "substantial factor" in causing Poliner's damages (Br. at 53), a requirement that the evidence satisfies.

Second, the fact that Poliner's damages continued long after May 1998 and thus "post-dated" the June suspension (*id.*) does not mean that the May actions were no longer a "substantial factor" in causing the damages. To the contrary, but for Defendants' unlawful actions in May 1998 that resulted in banning Poliner from the cath lab, Defendants would not have been able to summarily suspend Poliner at all (much less in a manner that any court would have immunized under the law).[24] And even if the June suspension *also*

---

the May abeyances did not proximately cause Cohen to stop the referrals. In fact, Cohen testified that the abeyances did affect his decision to do so. (3RR805)

[24] If Knochel had merely asked for Poliner's agreement to the abeyance without making any unlawful threats, Poliner would have declined and thus would have been faced with either corrective action or suspension under the bylaws. Knochel could not have lawfully imposed a suspension, and under corrective action, Poliner could not have been suspended without first being

contributed to Poliner's damages, that does not sever the causal link between the May forced abeyances and the resulting damages. This result is consistent with the jury charge, which, as noted above, focused the jury on damages resulting only from the May actions but did not limit "the scope or extent of Plaintiffs' injury and/or damages . . . to a particular time period." (CR6547-48)

VI. Defendants Are Not Entitled to a New Trial

The trial court correctly rejected Defendants' request for a new trial based on the sufficiency of the evidence (Br. at 54 n. 22) because, as discussed above, the evidence overwhelmingly supported the verdict. *See Lane v. R.A. Sims, Jr., Inc.*, 241 F.3d 439, 444 (5th Cir. 2001). The court also acted well within its discretion in refusing a new trial based on Defendants' three additional complaints.

---

heard by the same committee that ultimately vindicated him in November 1998. If Knochel had not spoken with Poliner but instead had assembled an ad hoc committee to review Poliner's cases, the committee would have taken weeks to make any recommendation. In the meantime, of course, Poliner would have been successfully treating patients in the cath lab on a regular basis (as he had done for the previous 20 years), thus making it impossible for any committee to conclude, reasonably and in good faith, that he constituted an imminent or present danger.

A. The Trial Court Correctly Determined that the Verdict Was Not the Product of Passion and Prejudice.

Defendants' first basis for a new trial -- that the size of the jury's awards alone evinces improper "passion and prejudice" -- is wrong as a matter of law and fact. (Br. at 54-55) As the Court held in *Edwards v. Sears, Roebuck & Co.*, 512 F.2d 276, 282 (5th Cir. 1975), "[a] jury's finding as to liability can be binding even though its monetary award is found to be excessive or even improperly influenced -- our deference to and faith in the jury system demands at least this much." While this Court on rare occasions has held that an award is so excessive that remittitur is an inadequate remedy, *see Wells v. Dallas Indep. Sch. Dist.*, 793 F.2d 679, 684 (5th Cir. 1984), that result is "not applicable" where a trial court expressly finds that the reduced award was "well supported by the evidence" and "was the product of reason, not passion." *Cimino v. Raymark Indus., Inc.*, 151 F.3d 297, 324 (5th Cir. 1998) (distinguishing *Wells*). The court below made these very findings based on its careful "observation of the trial." (CR6657) Specifically, the court found that "[t]here was nothing in the jurors' behavior to indicate that they were predisposed to Plaintiffs," and that the total award of actual and punitive damages, though excessive and subject to reduction, "was a product of reason -- not emotion -- resulting from a rational deduction [by the jury] that such action was necessary to compensate Dr.

Poliner and to effect change in Defendants' conduct in the future." (CR6657)[25]

Defendants cannot overcome these adverse findings by providing a list of alleged "overt plays to passion and prejudice." (Br. at 55 & n.23) This list is particularly unimpressive because the alleged "overt plays" are merely the ordinary incidents of any hard-fought and hotly-contested trial. Indeed, Defendants failed to object to virtually all of these comments at the time they were made, thereby waiving any complaint and belying Defendants' exaggerated contentions on appeal. (*See* 1RR132, 170, 219, 233; 3RR617, 659; 4RR843, 853; 7RR1673; 11RR2477, 2489, 2490-91, 2492-93, 2544-45) *Colburn v. Bunge-Towing, Inc.*, 883 F.2d 372, 376 (5th Cir. 1989). And the fact that Poliner's counsel were occasionally "warned" about their comments (Br. at 55 & n.25) shows only that the trial court exercised firm control over the courtroom in successfully eliminating any undue "passion and prejudice." *See, e.g.*, *Brown v. Parker Drilling Offshore Corp.*, 410 F.3d 166, 180-81 (5th Cir. 2005).[26] In short, the court correctly exercised its broad discretion in concluding that the jury's verdict was not motivated by passion and prejudice.

---

[25] The court did not, as Defendants imply, find that the jury's actual damages award "was meant to punish." (Br. at 56) In stating that "[t]here is no doubt that the size of this award clearly reflects the jury's desire to punish these Defendants and to compensate Dr. Poliner for the loss of his career," the court was addressing both the punitive and compensatory awards, respectively. (CR6657)

[26] The court also instructed the jury that "prejudice or sympathy" must not influence their decision (CR4444), and there is no basis for concluding that the jury disregarded that admonition. *Gray*, 6 F.3d at 271.

B. The Trial Court Correctly Exercised Its Discretion in Excluding the Hearing Committee's Endorsement of the June 1998 Suspension.

Contrary to Defendants' argument (Br. at 56-57), the trial court properly exercised its discretion in excluding the hearing committee's November 1998 letter, which reinstated Poliner but noted that the June 1998 suspension was justified "based on the evidence available to [Knochel] at the time." (DX-95) It is well-settled that a trial court has discretion to exclude evidence that is irrelevant or cumulative. FED. R. EVID. 401, 403. Here, the court correctly determined before trial that the hearing committee's self-serving endorsement of the June suspension was "irrelevant," given that Poliner was not permitted under the court's immunity ruling to attack the June suspension to which the letter referred. (PT-Hrg. 30-31, 34) Defendants' counsel even acknowledged that she "under[stood]" the basis for that ruling. (*Id.* at 34) Counsel was more concerned with being able to admit into evidence the letter's conditions on Poliner's reinstatement (*id.*), but the jury ultimately learned about these conditions through testimony and exhibits (3RR664; 7RR1470-72; PX-171).

Moreover, the statements in the letter about the June suspension were cumulative of other evidence the jury heard. For example, Harper volunteered that "[t]he committee recommended reinstatement of [Poliner's] privileges with monitoring, and authenticated that they believed the action that had been taken for his summary suspension was justified." (3RR664) This testimony virtually duplicated the contents of the letter. (DX-95) Indeed, in sustaining Poliner's objection to the letter when Defendants finally attempted to offer it toward the end of the trial, the court told Defendants' counsel, "I think you have in what you need to get in." (9RR2102) Based on the irrelevant and duplicative contents of DX-95, the trial court correctly exercised its discretion in excluding it.

C. The Trial Court Correctly Exercised Its Discretion in Admitting Dr. Dunn's Testimony.

Defendants' handful of perfunctory attacks on the testimony of Poliner's expert, Dr. John Dunn (Br. at 57-58), fails to establish that the trial court abused its discretion in allowing that testimony. *See Hodges v. Mack Trucks, Inc.*, 474 F.3d 188, 194 (5th Cir. 2006). Far from constituting "unhelpful, baseless legal conclusions" (Br. at 57), Dunn's testimony regarding the standards for a reasonable peer-review process, the degree to which Defendants deviated from that process, and the impact of Defendants' actions on Poliner's career (4RR965-1089) assisted the jury's understanding of the specialized and inscrutable world of medicine that is far beyond the average juror's experience. *See, e.g.*, *Brown*, 101 F.3d at 1333-34 (expert testified regarding propriety of peer-review procedures); *Bryan v. James E. Holmes Reg'l Med. Ctr.*, 33 F.3d 1318, 1331 n.22 (11th Cir. 1994) (same).

There is also no merit to Defendants' mischaracterization of Dunn's testimony as simply "reading Defendants' minds." (Br. at 57) Defendants' inapposite cases notwithstanding,[27] experts are allowed to testify to the ultimate issue at trial, FED. R. EVID. 704, including the presence of actual malice based on (among other facts) the failure to comply with professional standards. *See, e.g.*, *Suzuki Motor Corp. v. Consumers Union of U.S.*, 330 F.3d 1110, 1137 n.14 (9th Cir. 2003); *Bressler v. Fortune Magazine*, 971 F.2d 1226, 1228 (6th Cir. 1992).[28] And when the expert testifies about such subjects, there is no requirement, as Defendants suggest (Br. at 57-58), that the testimony be susceptible to testing methods applicable to scientific expert testimony. *See, e.g.*, *Pipitone v. Biomatrix, Inc.*, 288 F.3d 239, 247 (5th Cir. 2002).

Moreover, Dunn's testimony largely duplicated other evidence and thus could not have given rise to harmful error. *See, e.g.*, *Snyder v. Whittaker Corp.*, 839 F.2d 1085, 1090 (5th Cir. 1988). For example, like Dunn (4RR992-94, 1013, 1015-16), DeMaio also testified that Poliner was not a danger to his patients, that Defendants' procedure in obtaining the abeyances was unfair, that the actions taken against Poliner were unwarranted, that an abeyance is as damaging to a doctor's career as a suspension, and that the damage to Poliner's reputation was irreparable (6RR1336, 1338-45, 1400, 1446).[29]

---

[27] *Brueggemeyer v. American Broadcasting Cos., Inc.*, 684 F. Supp. 452, 463-66 (N.D. Tex. 1988), and *Freedom Newspapers of Texas v. Cantu*, 168 S.W.3d 847, 858-59 & n.48 (Tex. 2005) both involved "expert journalists" whose opinions lacked sufficient support and, in the case of *Brueggemeyer*, invoked an incorrect legal standard.

[28] Contrary to Defendants' claim (Br. at 58), Dunn also testified under the correct definition of actual malice (4RR1014-15). By erroneously arguing that the HCQIA "required no notice and hearing" (Br. at 58), Defendants simply disagree with Dunn's correct conclusions to the contrary.

VII. Further Remittitur Is Not Necessary or Appropriate.

Although the trial court reduced Poliner's damage awards for injury to career/reputation and mental anguish from $70 million to $21 million, Defendants now seek either greater reduction or outright vacatur. (Br. at 58-61) But such relief is neither necessary nor appropriate. Measured against the highly deferential standard of review that applies when a trial court has already granted remittitur, the court below did not abuse its discretion in setting damages at their present amounts. The court also correctly concluded that the "maximum recovery rule" did not require further reduction. And far from creating any duplicative recovery, the greatly reduced separate damages against the Hospital are appropriate given the Hospital's independent liability for its ratification of Knochel's actions.

A. The Trial Court's Exercise of Discretion in Setting a Reduced Amount of Actual Damages Should Not be Second-Guessed.

Defendants are incorrect in contending that no evidence supported the damage awards, as reduced by the trial court, for injury to career/reputation and mental anguish. (Br. at 59-60) This Court will not reverse a jury's damages verdict for excessiveness except on "the strongest of showings." *Caldarera v. Eastern Airlines, Inc.*, 705 F.2d 778, 784 (5th Cir. 1983). As a preliminary matter, juries are accorded "especially broad leeway" in awarding damages that are not readily quantifiable, such as injury to reputation and mental anguish. *Seidman v. American Airlines, Inc.*, 923 F.2d 1134, 1141 (5th Cir. 1991); *see also Bentley*, 94 S.W.3d at 605. This deference is magnified here, where the trial court has already reduced the jury's damage awards by remittitur to less than one-third of their original size. *Stapleton*, 608 F.2d at 574 n.7 ("Where the trial court has invoked its discretion in granting a remittitur, our scope of review is even narrower than usual.").

---

[29] Wharton (3RR714-19), Kern (4RR898, 933), Merrill (1RR215), and Knochel himself (2RR449-50) also duplicated portions of Dunn's testimony.

Defendants ignore this highly deferential standard of review and instead offer a one-sided view of the evidence in a light most favorable to their own argument. (*See* Br. at 22-23, 53-54, 59) Because Defendants' statements were defamatory *per se*, the existence of damages for injury to career/reputation and mental anguish are presumed without requiring specific evidence of harm. *See, e.g.*, *Bentley*, 94 S.W.3d at 604. But whether this Court considers the statements to be defamatory *per se* or *per quod*, the record amply supports both the fact and amount of damages as reduced by the trial court.

Injury to Career/Reputation. The court acted within its broad discretion in reducing the total award for injury to career and reputation to $10.5 million. *See, e.g.*, *Beaumont v. Basham*, 205 S.W.3d 608, 620-21

(Tex. App. -- Beaumont 2006, no pet.) (affirming award for injury to reputation that banker had established during career, based on reactions and "whispering" in banking community).[30] Before the events of May 1998, Poliner enjoyed a distinguished and unblemished career. (5RR1126-27, 1194-95; CR6653) His practice at the cath lab, which depended almost exclusively on referrals from other doctors, was thriving. (6RR1277-78, 1305; 7RR1661) As soon as Poliner was forced to put his cath lab privileges in abeyance, however, his referrals "dried up" and his practice "was gone." (6RR1303, 1305-11) The jury heard testimony that a loss of such privileges will permanently and irreparably ruin a physician's reputation. (4RR985, 1015-16; 6RR1342, 1345-46, 1444) Other physicians would no longer refer patients to a doctor, such as Poliner, who had been marked with a "scarlet letter" in this way. (3RR799; 6RR1342) Not only was Poliner unable to sustain any kind of practice at the Hospital (CR6654), but he was also precluded from teaching (6RR1324-27) and was rejected when he applied to work elsewhere (6RR1328-29). This and other evidence entitled the jury to conclude that Defendants' actions irreparably and permanently destroyed the sterling reputation and career that Poliner had built.

---

[30] Defendants' suggestion that the trial court did not reduce the awards further because of its "apparent disapproval of and desire to punish Defendants rather than actual compensation for any injury" (Br. at 59, citing RE11:6658) is inaccurate and misconstrues the court's order. In observing that "Defendants came across as arrogant, uncaring, and completely unconcerned with damaging Dr. Poliner's career," the court was summarizing its view of the evidence and the jury's reaction to it in awarding both actual and punitive damages. (CR6657-58)

In light of the enormity and permanence of this injury, and given the reality that a doctor's reputation is a priceless asset, the amount of the awards for injury to career and reputation should not be further reduced.

Mental Anguish. Similarly, the trial court's reduced awards totaling $10.5 million for mental anguish should not be further reduced. An award of mental anguish damages will be affirmed if the evidence demonstrates "the nature, duration, and severity of [plaintiffs'] anguish, thus establishing a substantial disruption in the plaintiffs' daily routine." *Parkway v. Woodruff*, 901 S.W.2d 434, 444 (Tex. 1995). Such evidence includes humiliation, family discord, shame, loss of self-esteem, and physical symptoms such as sleeping difficulties. *See, e.g.*, *Wyler Indus. Works, Inc. v. Garcia*, 999 S.W.2d 494, 509 (Tex. App. -- El Paso 1999, no pet.). Because considerations of mental anguish are "particularly within the jury's province," the jury has "broad discretion" to fix the amount of such damages. *Marvelli v. Alston*, 100 S.W.3d 460, 482 (Tex. App. -- Fort Worth 2003, pet. denied).

Poliner and his wife offered substantial evidence that, as a direct result of Defendants' conduct in May 1998, he experienced a severe and long-lasting disruption of his personal life. He was "devastated" by the experience (6RR1301) and changed from "a relaxed, busy person trying to make his practice grow, to an intense, saddened person" (7RR1676). He largely abandoned the family activities he once enjoyed, such as swimming and skiing with his children and taking walks with his wife, and instead spent countless hours pouring over patient records and the accusations against him. (7RR1653, 1671-73) The children "lost" their parents and the family "just became sad," marked by tension and melancholy. (7RR1676) Poliner experienced intense humiliation at being branded a dangerous doctor, and felt "like an outcast" in the medical community. (6RR1302, 7RR1605-06) He also began to suffer from elevated blood pressure and lost sleep. (7RR1671, 1677-78) Based on this and other evidence, the trial court acted well within its discretion in fixing the mental anguish awards at their present levels.

B. The Trial Court Correctly Determined that the Maximum Recovery Rule Does Not Apply Here.

Defendants' argument that the remitted damages should have been further reduced -- based simply on a comparison with one other case involving suspended physicians -- is premised on a misconception of the "maximum recovery rule" and ignores the unique circumstances of this case. (Br. at 60-61) Despite Defendants' suggestion to the contrary, "[a]n appellate court may not determine excessiveness by comparing verdicts in similar cases, but rather must review each case on its own facts." *Moore v. Angela MV*, 353 F.3d 376, 384 (5th Cir. 2003). While comparisons to damage awards in analogous cases "provide an objective frame of reference," they do "not control [this Court's] assessment of individual circumstances." *Id*. at 384 & n.8. Moreover, a departure from prior awards is appropriate "if unique facts are present that are not reflected within the controlling caselaw." *Douglass v. Delta Air Lines, Inc.*, 897 F.2d 1336, 1339 (5th Cir. 1990).

Based on these principles, the court below correctly rejected Defendants' invitation to reduce these damage awards roughly to the level of the lost earnings damages in *Rea v. Hospital Corp. of America*, 892 F. Supp. 821 (N.D. Tex. 1994). As the court noted, despite superficial similarities, *Rea* differs in "some very key respects." (CR6618) First, the physicians in *Rea* did not rely on referrals for their business, as Poliner did, and thus did not suffer the same "decimation" to their businesses, and concomitant mental anguish, by being suspended. (*Id.*) Second, the two cases involve distinct elements of damages: in *Rea*, the district court awarded damages only for "lost earnings," and not for other injuries such as mental anguish or the devastation to a career and reputation. *Rea*, 892 F. Supp. at 832. Comparing the awards in this case, which compensated Poliner for injury to reputation/career and mental anguish, to the award in *Rea*, which concerned only lost earnings under an entirely different set of facts, is an inappropriate exercise under this Court's precedent. *See Vogler v. Blackmore*, 352 F.3d 150, 157-58 (5th Cir. 2003) (declining to apply maximum recovery rule); *Moore*, 353 F.3d at 384-85; *Douglass*, 897 F.2d at 1345. The trial court was therefore correct in finding the maximum recovery rule to be inapplicable.[31]

---

[31] In a footnote, Defendants argue that these awards also violate unspecified "constitutional guarantees" and that "[f]urther remittitur of actual damages requires re-examination of punitive damages." (Br. at 61 n.29) Defendants, however, have waived these conclusory arguments by inadequately briefing them on appeal. *See, e.g., Shell Offshore, Inc. v. Office of Workers' Comp. Programs*, 122 F.3d 312, 317 (5th Cir. 1997).

C. The Evidence Supports the Separate Damage Awards Against the Hospital.

Finally, Defendants wrongly contend that the damage awards against the Hospital are "duplicative" of the awards against Knochel and lack independent evidentiary support. (Br. at 61) The claim of "duplication" fails for the basic reason that the court instructed the jury to "[c]onsider each Defendant separately" and not to "include damages as to one Defendant in assessing damages against any other Defendant." (CR4469) Because "juries are presumed to follow their instructions," *Gray*, 6 F.3d at 271, and the jury here obviously did so by assessing different damage amounts against the Hospital and Knochel (*see* CR6649-50, 7272), the Court should reject the unfounded notion that the jury awarded the same damages against the Hospital as it did against Knochel.

Moreover, the separate damage awards against the Hospital flow from the separate liability findings against it, and are supportable because of its vicarious liability for the actions of Knochel and others. *See Knutson v. Morton Foods, Inc.*, 603 S.W.2d 805, 807 (Tex. 1980) ("plaintiff could separately sue an employee and his employer and recover from both of them, so long as he did not recover more than one satisfaction"). The awards are also supportable because of the Hospital's acquiescence in and ratification of those actions. *See Prunty v. Arkansas Freightways, Inc.*, 16 F.3d 649, 652-53 & n.12 (5th Cir. 1994) (principal with knowledge of the facts may be independently liable for damages based on its agent's tortious acts that it adopts or fails to repudiate). Here, Knochel informed the Hospital's president and others about his two-option approach to Poliner (*i.e.*, accept an abeyance or be suspended), and while Knochel claimed he would have "backed off" his decision if any of them had objected, they did not object but in fact "acquiesced" and "agreed" to his plan. (2RR256-57, 402-06, 412) Although the Hospital's president lacked any information that Poliner was a dangerous doctor, he also failed to take any corrective action after learning that Knochel's threat was carried out. (1RR202) *See Prunty*, 16 F.3d at 652-55. Based on the Hospital's independent actions, the jury was more than justified in awarding Poliner separate damages against the Hospital for his injury to career/reputation and mental anguish.

CONCLUSION

The amended final judgment should be affirmed in its entirety or, alternatively, affirmed as modified (as set forth in part V(B)).

Respectfully submitted,

/s/
Jeffrey S. Levinger
Thomas F. Allen, Jr.
Dustin B. Benham
Carrington, Coleman, Sloman & Blumenthal, L.L.P.
901 Main Street, Suite 5500
Dallas, Texas 75202
Telephone: 214-855-3000
Telecopier: 214-855-1333

Michael A. Logan
Karin M. Zaner
Kane, Russell, Coleman
& Logan, P.C.
3700 Thanksgiving Tower
1601 Elm Street
Dallas, Texas 75201
Telephone: 214-777-4200
Telecopier: 214-777-4299

Attorneys for Appellees

[Certificate of Service and Certificate of Compliance Omitted in this Appendix]

114

④

No. 08-543

Supreme Court, U.S.
FILED
DEC 12 2008
OFFICE OF THE CLERK
OFFICE OF [illegible]

In The
Supreme Court of the United States

◆

LAWRENCE R. POLINER, M.D.,
LAWRENCE R. POLINER, M.D., P.A.,

Petitioners,

v.

TEXAS HEALTH SYSTEM, DOING BUSINESS AS
PRESBYTERIAN HOSPITAL OF DALLAS, TEXAS,
A TEXAS NON-PROFIT CORPORATION,
JAMES KNOCHEL, M.D.,

Respondents.

◆

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

◆

BRIEF IN OPPOSITION OF RESPONDENTS

◆

THOMAS S. LEATHERBURY*
GABRIELA A. GALLEGOS
VINSON & ELKINS L.L.P.
2001 Ross Avenue
Suite 3700
Dallas, Texas 75201
(214) 220-7700

LEA F. COURINGTON
CURRAN TOMKO TARSKI LLP
2001 Bryan Street
Suite 2050
Dallas, Texas 75201
(214) 270-1400

Counsel for Respondents

December 12, 2008

**Counsel of Record*

COCKLE LAW BRIEF PRINTING CO. (800) 225-6964
OR CALL COLLECT (402) 342-2831

QUESTION PRESENTED

Whether the court of appeals correctly applied the objective "reasonable belief" standard in the immunity provisions of the Health Care Quality Improvement Act, 42 U.S.C. §§ 11112(a)(1) and (4), by following the settled, uniform caselaw from other circuits.

LIST OF PARTIES AND CORPORATE DISCLOSURE STATEMENT

Petitioners Lawrence R. Poliner, M.D. ("Poliner") and Lawrence R. Poliner, M.D., P.A. (the "Professional Association") (collectively "Petitioners") were plaintiffs in the trial court. This Court has no jurisdiction over claims by the Professional Association as it won no relief in the Amended Final Judgment, never filed a notice of appeal from the Amended Final Judgment, and dismissed its cross-appeal from the original Final Judgment. *See* Jurisdiction, *infra* at 1.

Respondents Texas Health Resources (sued here as Texas Health System, doing business as Presbyterian Hospital of Dallas, a Texas non-profit corporation) ("PHD") and James Knochel, M.D. ("Knochel") (collectively "Respondents") were defendants in the trial court and appellants in the Court of Appeals. Charles Harris, M.D., Anthony Das, M.D., Charles Levin, M.D., David Musselman, M.D., John Harper, M.D., Robert Brockie, M.D., Jorge Cheirif, M.D., Steven Meyer, M.D., and Martin Berk, M.D. were additional defendants in the trial court.

In the Fifth Circuit, the following entities appeared as *amici curiae* supporting Respondents: Health Care Indemnity Corporation, American Hospital Association, Texas Hospital Association, Children's Medical Center of Dallas, The Methodist Hospital, Mississippi Hospital Association, North Mississippi

LIST OF PARTIES – Continued

Health Services, Inc., Our Lady of the Lake Hospital, Inc., Rush Health Services, Summa Health System, Tenet Healthcare Corporation, and Texas Children's Hospital.

The Association of American Physicians and Surgeons, Inc. ("AAPS"), appeared in the Fifth Circuit as *amicus curiae* supporting Petitioners, as it has, too, in this Court. The Semmelweis Society International, Inc. ("SSI") has also appeared in this Court as *amicus curiae* supporting Petitioners.[1]

Pursuant to Supreme Court Rule 29.6, Respondents make the following disclosures:

Texas Health Resources (sued here as Texas Health System, doing business as Presbyterian Hospital of Dallas, a Texas non-profit corporation) is a Texas non-profit corporation. Presbyterian Hospital of Dallas is also a Texas non-profit corporation. As non-profits, neither has a parent company, and neither has issued any stock.

---

[1] However, Petitioners did not consent to the filing of SSI's brief, and SSI's Motion for Leave to File is still pending.

TABLE OF CONTENTS

Page

QUESTION PRESENTED i

LIST OF PARTIES AND CORPORATE DISCLOSURE STATEMENT ii

TABLE OF CONTENTS iv

TABLE OF AUTHORITIES vi

OPINIONS BELOW 1

JURISDICTION 1

STATUTES INVOLVED 2

INTRODUCTION 2

STATEMENT OF THE CASE 5

REASONS FOR DENYING THE PETITION 16

I. AS PETITIONERS ADMIT, THERE IS NO CONFLICT AMONG THE COURTS OF APPEALS OVER THE OBJECTIVE REASONABLENESS STANDARD UNDER HCQIA 16

II. THE FIFTH CIRCUIT CORRECTLY APPLIED HCQIA IN REVERSING AND RENDERING JUDGMENT FOR RESPONDENTS 27

III. ADDITIONAL, DISPOSITIVE LEGAL ISSUES, RECOGNIZED BUT NOT DECIDED BY THE FIFTH CIRCUIT, ALSO MAKE THIS AN INAPPROPRIATE CASE FOR THIS COURT TO REVIEW 30

CONCLUSION 31

TABLE OF CONTENTS – Continued

Page

APPENDIX A – AMENDED FINAL JUDGMENT (Nov. 20, 2006) .... App. 1

APPENDIX B – MEMORANDUM OPINION AND ORDER (Nov. 17, 2006) .... App. 4

TABLE OF AUTHORITIES

Page

CASES

Austin v. McNamara, 979 F.2d 728 (9th Cir. 1992) 20, 21

Brader v. Allegheny Gen. Hosp., 167 F.3d 832 (3d Cir. 1999) 20

Brown v. Presbyterian Healthcare Servs., 101 F.3d 1324 (10th Cir. 1996) 16, 17, 20, 22, 25

Bryan v. James E. Holmes Reg'l Med. Ctr., 33 F.3d 1318 (11th Cir. 1994) 3, 17, 20, 22, 27

Dallas County Med. Soc'y v. Ubiñas-Brache, 68 S.W.3d 31 (Tex. App. – Dallas 2001, pet. denied) 24

Doe v. La. Psychiatric Med. Ass'n, No. 96-30232, 1996 WL 670414 (5th Cir. Oct. 28, 1996) 17

Freilich v. Upper Chesapeake Health, Inc., 313 F.3d 205 (4th Cir. 2002) 20

Imperial v. Suburban Hosp. Assoc., Inc., 37 F.3d 1026 (4th Cir. 1994) 20

Islami v. Covenant Med. Ctr., Inc. 822 F. Supp. 1361 (N.D. Iowa 1992) 25

Lee v. Trinity Lutheran Hosp., 408 F.3d 1064 (8th Cir. 2005) 27

TABLE OF AUTHORITIES – Continued

Page

Maewal v. Adventist Health Sys./Sunbelt, Inc., 868 S.W.2d 886 (Tex. App. – Fort Worth 1993, writ denied) 24

Mathews v. Lancaster Gen. Hosp., 87 F.3d 624 (3d Cir. 1996) 17, 20, 22

Meyers v. Columbia/HCA Healthcare Corp., 341 F.3d 461 (6th Cir. 2003) 20

Poliner v. Texas Health Sys., No. Civ. A. 3:00-CV-1007-P, 2006 WL 770425 (N.D. Tex. Mar. 27, 2006) 12

Roe v. Walls Reg'l Hosp., 21 S.W.3d 647 (Tex. App. – Waco 2000, no pet.) 24

Singh v. Blue Cross/Blue Shield of Mass., Inc., 308 F.3d 25 (1st Cir. 2002) 16, 20, 22

Smith v. Ricks, 31 F.3d 1478 (9th Cir. 1994) 17, 20,22

St. Luke's Episcopal Hosp. v. Agbor, 952 S.W.2d 503 (Tex. 1997) 24

Sugarbaker v. SSM Health Care, 190 F.3d 905 (8th Cir. 1999) 16, 17, 20, 22

Statutes and Rules

Fed. R. Civ. P. 50 23

Tex. Civ. Prac. & Rem. Code § 41.008 13

Tex. Occ. Code § 160.010 11

42 U.S.C. § 11111(a) 2

42 U.S.C. § 11112(a) .... *passim*

Page

42 U.S.C. § 11112(c) 12, 29

42 U.S.C. § 11115(a) 23

LEGISLATIVE HISTORY

H.R. Rep. No. 903, at 10, (1986), *as reprinted in* 1986 U.S.C.C.A.N. 6392-93 .... 4, 23

OTHER AUTHORITIES

Scott M. Smith, Annotation, *Construction and Application of Health Care Quality Improvement Act of 1986*, 121 A.L.R. FED. 255 (1994 and Supp. 2004) 25

OPINIONS BELOW

Petitioners attached the wrong judgment to their petition. Pet. App. at 62a-65a. Petitioners attached the original Final Judgment entered on October 13, 2006. Subsequently, the trial court granted in part Respondents' Motion to Alter or Amend Final Judgment and entered an Amended Final Judgment on November 20, 2006. The Amended Final Judgment is attached as Appendix A, Opp. App. at 1-3, and the court's Memorandum Opinion and Order granting in part Respondents' Motion to Alter or Amend Final Judgment is attached as Appendix B. Opp. App. at 4-12; *see infra* at 11-14 for the chronology of the district court's several pre-trial and post-trial opinions.[2]

◆

JURISDICTION

The Court does not have jurisdiction over any claims by Lawrence R. Poliner, M.D., P.A. (the "Professional Association"). The Professional Association obtained no relief in the Amended Final Judgment, never filed a notice of appeal from the Amended Final Judgment, and dismissed its cross-appeal from the original Final Judgment. The Professional Association has therefore abandoned its claims.

◆

---

[2] Additionally, the Westlaw opinion cited by Petitioners (Pet. at 1), 2003 WL 22255677 (N.D. Tex. Sept. 30, 2003), is the district court's summary judgment opinion, not a post-verdict opinion.

STATUTES INVOLVED[3]

(c) Adequate procedures in investigations or health emergencies.

For purposes of Section 11111(a) of this title, nothing in this section shall be construed as –

(1) requiring the procedures referred to in subsection (a)(3) of this section –

* * *

(B) in the case of a suspension or restriction of clinical privileges, for a period of not longer than 14 days, during which an investigation is being conducted to determine the need for a professional review action; or

(2) precluding an immediate suspension or restriction of clinical privileges, subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action may result in an imminent danger to the health of any individual.

◆

INTRODUCTION

Petitioners seek this Court's review of a unanimous panel decision of the Fifth Circuit, authored by Judge Higginbotham, that properly applied the well-established standards for immunity under the

---

[3] Petitioners omitted these portions of HCQIA on which the Fifth Circuit relied.

Health Care Quality Improvement Act ("HCQIA") to restrictions on Poliner's medical staff privileges that lasted less than one month. *See* 42 U.S.C. § 11112(a).[4] Petitioners single out the "reasonable belief" standard contained in 42 U.S.C. Sections 11112(a)(1) and (4) and contend that the Fifth Circuit and every other Circuit Court that has addressed the issue has wrongly held that "reasonable belief" is judged by an objective standard and that evidence of alleged bias or improper motive is irrelevant to the determination of objective reasonableness. As the Fifth Circuit summarized, "We agree with our sister circuits that the HCQIA's 'reasonableness requirements were intended to create an objective standard of performance, rather than a subjective good faith standard.'" Pet. App. at 18a (footnote omitted – *quoting Bryan v. James E. Holmes Reg'l Med. Ctr.*, 33 F.3d 1318, 1323 (11th Cir. 1994), and collecting cases). Petitioners repeatedly admit that there is no conflict on this issue in the Courts of Appeals and that the Fifth Circuit followed settled law in reversing and rendering judgment for Respondents. *See, e.g.*, Pet. at 8, 9, 10, 11-12, 20,[5] 25, 30, 33.[6]

---

[4] Former Chief Judge King and Judge Southwick joined in the opinion.

[5] "One by one, circuit courts of appeals have parroted this erroneous standard. . . . Thus, each and every case in which the 'reasonable belief' prongs of immunity have been analyzed by a circuit court of appeals has been dismissed as a matter of law based on federal immunity." Pet. at 20.

[6] Amicus SSI disagrees with Petitioners on this issue and unconvincingly tries to manufacture a circuit conflict with

(Continued on following page)

Petitioners' real complaint is with the policy decision Congress made in passing the qualified immunity provisions of HCQIA to protect doctors and hospitals that engage in peer review from chilling, inflated damages claims by the physicians whose conduct is reviewed. *See* Pet. App. at 16a-17a, 36a. Congress made clear in the plain language of the statute and in the legislative history that courts should use an objective test,[7] and that is what the courts have uniformly done. Petitioners offer no indication that Congress has ever disapproved of this uniform construction. Petitioners should lodge their complaint with Congress, not with this Court. Certiorari should be denied.

◆

---

confusing, inconsequential snippets of case quotations relating to various issues under HCQIA and various state peer review statutes. SSI Br. at 9-15. There is no conflict in the Circuit Courts about the use of an objective standard to determine the existence of a "reasonable belief" under HCQIA. *See infra* at 16-22.

[7] "The Committee intends that this [reasonable belief] test will be satisfied if the reviewers, with the information available to them at the time of the professional review action, would reasonably have concluded that their action would restrict incompetent behavior or would protect patients." H.R. Rep. No. 903, at 10, (1986), *as reprinted in* 1986 U.S.C.C.A.N. 6392-93; *see* Pet. App. at 21a-22a.

STATEMENT OF THE CASE

While Petitioners label the facts "quite complex," Pet. at 5, they do not discuss them.[8] Even a brief overview demonstrates that the Fifth Circuit correctly held that Respondents' temporary restriction of Poliner's cardiac catheterization privileges was immune under HCQIA as a matter of law. *See* Pet. App. at 3a-12a.

By May 1998, a series of complaints had raised concerns about cardiologist Poliner's medical judgment and technical skill and the quality of his patient care. The PHD Clinical Risk Review Committee had requested that Knochel, a kidney specialist and the chairman of the Internal Medicine Department, investigate the following complaints in consultation with the Internal Medicine Advisory Committee ("IMAC"):

> Fall 1996: Patient 10, who had known allergies to iodine (or Betadine) and had refused pretreatment with Benadryl, suffered a post-procedure, allergic reaction, ostensibly to the iodine-containing contrast dye injected into her arteries. *Id.* at 6a n.7. The IMAC initially found concerns about Poliner's care,

---

[8] The approach of amicus AAPS toward the facts is cavalier, and its tone disturbing. *See, e.g.,* AAPS Br. at 7-8 (complaints about Poliner's performance were "frivolous," "contrived," and "medically insignificant"), 5 ("a charade"), 20 (comparing patients to shoppers), 11 (Fifth Circuit "rubber stamp[ed] the corrupt prior review").

including lack of documentation for the patient's need for the procedure and lack of knowledge about which contrast dye he had used, but cleared the case after it received Poliner's response and after Poliner was counseled on documentation and contrast dye issues. *Id.* at 6a-7a.

September 1997: Patient 18, an 88-year-old woman, became hypotensive and died in the cardiac catheterization lab when Poliner attempted an arguably unnecessary 2:00 a.m. angioplasty. *Id.* at 6a n.8. The cardiologist who reviewed Poliner's performance on this case, at Knochel's request, criticized Poliner's judgment and skill, finding, among other things, that Poliner failed timely to acquire access to the patient's artery, to appreciate the significance of obvious bleeding, and to consider all possibilities in treating the patient's hypotension.

October 1997: Patient 9 suffered a hemorrhagic stroke from bleeding in the brain following a procedure that Poliner performed; Poliner chose not to come to the hospital to examine the patient even though a nurse advised him of significant changes in the patient's condition, and Poliner did not order a neurological consult or a CT scan until he arrived at the hospital hours later. *Id.* at 6a n.6. Dr. Levin, who reviewed this case at Knochel's request, criticized, among other things, Poliner's failure to adequately and timely assess the patient despite serious changes in the patient's condition.

> December 1997: Patient 3, a 75-year-old man admitted for diagnostic cardiac catheterization, was exposed to potential infection because Poliner reused the original sheath site for a second procedure. Poliner left the original sheath in for two days, twice as long as is standard procedure, then exchanged it for a new sheath before performing angioplasty using the same site despite staff concerns about infection and contamination by blood and urine. *Id.* at 6a n.5. The physician who reviewed this complaint also criticized Poliner's judgment and deviation from standard procedure.
>
> January 1998: Patient 39 suffered complications when Poliner failed to recognize that he had mistakenly inserted the catheter into a vein instead of an artery until he had threaded the catheter all the way to the patient's heart. *Id.* at 7a n.9.

On May 12, 1998, the complaints concerning Patient 18 (death), Patient 9 (post-procedure stroke), and Patient 3 (contaminated sheath site) still remained under review by the IMAC and Dr. Knochel. *Id.* at 7a. On that day, Poliner committed the serious, life-threatening, and admitted mistakes on Patient 36 that led to the temporary restrictions on Poliner's medical staff privileges that became the subject of his damage claims below. *Id.* at 3a-5a, 7a-8a.

Patient 36, a 43-year-old man, was admitted with chest pain. Poliner admitted in writing that he misread the electrocardiogram and diagnostic film and failed to see that the patient's left anterior descending artery was completely blocked. Poliner operated on the patient's right coronary artery instead, caused multiple tears that required repair with five stents, and possibly caused a heart attack. As a result of the stents required to patch the tears Poliner made during the procedure, Patient 36 was administered an anti-coagulant. He suffered serious internal bleeding. After Poliner failed to answer multiple pages from nursing staff regarding his deteriorating patient, a critical-care specialist was called in. Patient 36 had to be intubated, put on a respirator, and given supportive drug therapy. *See id.* at 3a-5a. But for the critical care specialist, Patient 36 would have died within an hour from blood loss.[9]

The life-threatening emergency that Poliner created with Patient 36, plus the other pending complaints and the negative trends in Poliner's performance, led Knochel to conclude that Poliner's privileges should be temporarily restricted pending a further investigation. *Id.* at 7a-8a. On May 13, 1998, after consulting with appropriate colleagues, Knochel requested, under the PHD Medical Staff Bylaws, that Poliner agree to place his cardiac catheterization privileges in temporary abeyance for up to 15 days so that his performance could be reviewed and evaluated. *Id.* at 7a.[10] When Poliner asked what his options were, Knochel stated that the "alternative was suspension of his privileges." *Id.* at 8a. On May 14, Poliner signed the first abeyance agreement and hired a lawyer. *Id.*

---

[9] AAPS's suggestion that all of these patient cases were somehow selected in bad faith and that the jury so found has no support in the record. AAPS Br. at 3, 7-8; *see* Pet. App. at 3a-7a. AAPS's further complaint that these cases were "*not* representative" of Dr. Poliner's performance is meaningless under HCQIA and is belied by the record. AAPS Br. at 8 (original emphasis); *see* Pet. App. at 21a, 8a-9a (Poliner does not challenge the ad hoc committee finding that he administered substandard care in more than half of the cases studied).

Knochel then appointed an ad hoc committee of six cardiologists to review Poliner's performance. The ad hoc committee reviewed 44 of Poliner's cases and "concluded that Poliner gave substandard care in more than half." *Id.* at 9a.[11] The IMAC met on May 27, 1998 to consider the ad hoc committee's report and recommended that the temporary restrictions on Poliner's privileges be extended so that additional reviews of some of Poliner's echocardiograms could be conducted. *Id.* On May 29, Poliner, who was represented by counsel, signed the second abeyance agreement, extending the restrictions for an additional 14 days. *Id.*

---

[10] AAPS's statement that "Respondents themselves had no genuine concern about these cases" is false. AAPS Br. at 3; *see* Pet. App. at 6a-10a, 22a-23a. At trial, even Petitioners' own cardiology experts uniformly testified that Poliner's performance raised patient safety concerns and warranted review.

[11] AAPS is silent about these cases and the ad hoc committee's findings.

On June 11, Poliner met with the IMAC, and on June 12, the IMAC unanimously recommended that Poliner's cardiac catheterization and echocardiography privileges be suspended given the following, specific concerns: "(1) poor clinical judgment; (2) inadequate skills, including angiocardiography and echocardiography; (3) unsatisfactory documentation of medical records; and (4) substandard patient care." *Id.* at 10a. Knochel accepted the IMAC's recommendation and suspended Poliner's cardiac catheterization and echocardiography privileges. *Id.*[12]

Poliner requested that a PHD Hearing Committee review the suspension. In November 1998, the Hearing Committee found "that the June 12 suspension should be upheld based on the evidence that was available at the time" but recommended that Poliner's privileges be reinstated with monitoring. *Id.* at 11a.[13]

In May 2000, Poliner sued PHD, Knochel, and nine cardiologists who participated in Poliner's peer review, alleging violations of federal and state antitrust laws and the Texas Deceptive Trade Practices Act, defamation, breach of contract, tortious interference, and intentional infliction of emotional distress. *Id.* at 12a. Poliner later added his Professional

---

[12] Petitioners do not challenge the June 12 suspension of Poliner's privileges. *See* Pet. App. at 21a.

[13] AAPS's statement that PHD "absolved" Poliner "of anything improper" is also false. AAPS Br. at 3; *see* Pet. App. at 11a.

Association as a plaintiff. After discovery, the court (the Honorable Jorge Solis) granted in part the motion for summary judgment filed by all defendants. *Id.* at 71a-115a. The court dismissed Poliner's antitrust and Deceptive Trade Practices Act claims. *Id.* at 86a-92a, 114a. The court further held that all defendants were immune under HCQIA and the Texas peer review statute[14] for all claims concerning the June 1998 suspension. *Id.* at 94a-110a.[15] However, the court denied the motion for summary judgment of Respondents and Doctors Levin and Harper on Poliner's claims relating to the abeyances – the temporary restrictions preceding the June 1998 suspension. *Id.* at 94a-110a.[16]

At trial, the jury found that Poliner had not agreed to the abeyances and found against Respondents, Harper, and Levin on the peer review immunity issues and for Petitioners on all claims (defamation, contract, tortious interference, business disparagement, and intentional infliction of emotional distress). The jury assessed damages exceeding $366,000,000, including $110,000,000 in punitive damages. *Id.* at 116a-162a.

---

[14] TEX. OCC. CODE § 160.010.

[15] In a subsequent pre-trial order, the court clarified that Petitioners could not recover damages for the immune June 1998 suspension. Pet. App. at 66a-70a.

[16] The Fifth Circuit detailed the dramatic shift in Petitioners' theory of the case in light of the partial summary judgment order and Petitioners' consequent, improper focus on the standards under the PHD Medical Staff Bylaws rather than on the standards under HCQIA. Pet. App. at 13a-15a.

Petitioners moved for judgment against Respondents, requesting $70,000,000 in defamation damages, $10,526.55 in breach of contract damages, $1,900,000 in attorneys' fees, and $90,000,000 in punitive damages.[17] Respondents filed a renewed motion for judgment as a matter of law and motions for new trial and remittitur.

In a series of opinions and orders on March 27, 2006, September 18, 2006, October 6, 2006, and October 13, 2006, the court denied Respondents' renewed motion for judgment as a matter of law and motion for new trial, but granted Respondents' motion for remittitur. *See Poliner v. Texas Health Sys.*, No. Civ. A. 3:00-CV-1007-P, 2006 WL 770425, at *1 (N.D. Tex. Mar. 27, 2006); Pet. App. at 38a-61a (Oct. 13, 2006). The court held that it would enter judgment on Poliner's defamation claim in order to maximize Poliner's recovery.[18] The court further held that

---

[17] Harper and Levin settled with Petitioners after verdict.

[18] Poliner advanced a novel defamation claim – that the two abeyance decisions constituted defamatory "statements" that somehow branded Poliner a "dangerous" doctor. *See* Pet. App. at 13a-15a. This argument tried not only to turn defamation law on its head but also to eviscerate the immunity HCQIA provides to doctors and hospitals that make objectively reasonable decisions to temporarily suspend a physician's privileges during a peer review investigation. *See* 42 U.S.C. §§ 11112(a) and (c)(1)(B). Poliner further argued, without any better basis, that the alleged false, defamatory statements also included unattributed

(Continued on following page)

the jury's awards, totaling $70,000,000 in non-economic damages and $90,000,000 in punitive damages, were excessive, irrational, and unsupported, but declined to find that the awards were the product of passion and prejudice. Although Poliner proved no economic damages,[19] the court set Poliner's non-economic defamation damages at $21,000,000. The court also remitted punitive damages against each Respondent to the maximum amount under the applicable Texas statute, TEX. CIV. PRAC. & REM. CODE § 41.008. *See* Pet. App. at 38a-61a.

After Petitioners accepted the remittitur, the court *sua sponte* added $7,894.92 in economic damages and entered the original Final Judgment on October 13, 2006. *Id.* at 62a-65a.

Respondents again renewed their post-verdict motions and also moved to alter or amend the judgment. The court denied Respondents' renewed motions, but granted in part their Motion to Alter or Amend by deleting both the defamation award to the Professional Association (because the Professional Association never submitted a defamation claim to the jury) and the award of economic damages

---

rumors about the abeyances, the internal memorandum by which Knochel appointed the ad hoc committee, and Knochel's truthful response to an inquiry about Poliner's privileges from the Kansas Physician Information Verification Program. *See* Pet. at 3-4 and n.4; Pet. App. at 225a-230a.

[19] In fact, the Professional Association took in more than $1,200,000 in 2000.

(because Poliner proved no economic damages). Opp. App. at 10-12.

The Amended Final Judgment awarded Poliner $22,500,000 in non-economic and punitive damages for defamation: $12,750,000 against Knochel ($6,000,000 for injury to career/reputation; $6,000,000 for mental anguish; and $750,000 for punitive damages) and an additional $9,750,000 against PHD ($4,500,000 for injury to career/reputation; $4,500,000 for mental anguish; and $750,000 for punitive damages). *Id.* at 2.[20]

Consequently, for alleged false statements relating solely to temporary restrictions on Poliner's cardiac catheterization privileges which lasted less than one month, Poliner recovered $10,500,000 for injury to career/reputation, $10,500,000 for mental anguish, and $1,500,000 in punitive damages. The court's prejudgment interest award, entered over repeated objections, added over $11,000,000 to the Amended Judgment. Pet. App. at 15a.

Respondents timely filed joint notices of appeal to the Fifth Circuit, and Petitioners filed a notice of cross-appeal from the original Judgment (but not from the Amended Final Judgment). Petitioners then voluntarily dismissed their cross-appeal.[21]

---

[20] The Amended Judgment did not award any relief to the Professional Association. Opp. App. at 1-3; *see supra* at 1.

[21] Petitioners thus dropped any challenge to the trial court's summary judgment holding that, as a matter of law, Respondents were immune under HCQIA and the Texas medical peer

(Continued on following page)

The unanimous Fifth Circuit panel issued its decision on July 23, 2008, reversing the Amended Final Judgment and rendering judgment in favor of Respondents. Pet. App. at 1a-37a. The court decided the case solely on the basis of HCQIA immunity, holding that each of the two abeyance decisions, which temporarily restricted Poliner's cardiac catheterization privileges, constituted a professional review action that was immune from damage claims under HCQIA as a matter of law. *Id.* at 3a, 16a-37a. The court further wrote: "Because Defendants are immune under the HCQIA, we have no occasion to consider Defendants' other substantial arguments that we must reverse and render judgment based on state law immunity and because Poliner failed to prove the substantive elements of his claims. . . . Nor need we reach the compelling arguments that, at the very least, we would have to reverse and remand for a new trial because of the jury's excessive verdict and manifest trial errors." *Id.* at 37a.

No motion for rehearing or rehearing en banc was filed. On October 7, Poliner filed a *pro se* application to extend time to file a petition for certiorari. Justice Scalia denied the application on October 16. Only five days later, on October 21, Petitioners' long-time counsel filed the Petition for Writ of Certiorari.[22]

---

review statute for the five-month suspension of Poliner's privileges beginning on June 12, 1998. Pet. App. at 21a.

[22] Poliner previously indicated that he would try to raise money from medical associations and other organizations to

(Continued on following page)

AAPS has filed an amicus brief supporting Petitioners, and SSI's Moton for Leave to File is pending.[23]

◆

REASONS FOR DENYING THE PETITION

I. AS PETITIONERS ADMIT, THERE IS NO CONFLICT AMONG THE COURTS OF APPEALS OVER THE OBJECTIVE REASONABLENESS STANDARD UNDER HCQIA.

Throughout their petition, Petitioners admit that there is no conflict in the Circuit Courts of Appeals and that the Fifth Circuit followed well-established law in applying an objective standard under Sections 11112(a)(1) and (4). *See, e.g.*, Pet. at 8, 9, 10, 11-12, 20, 25, 30, 33. The Fifth Circuit, expressly following its sister circuits, wrote: "We agree with our sister circuits that the HCQIA's 'reasonableness requirements were intended to create an objective standard of performance, rather than a subjective good faith standard.'" Pet. App. at 18a and at n.26 (quoting *Bryan*, 33 F.3d at 1323, and *citing Singh v. Blue Cross/Blue Shield of Mass., Inc.*, 308 F.3d 25, 32 (1st Cir. 2002); *Sugarbaker v. SSM Health Care*, 190 F.3d 905, 912 (8th Cir. 1999); *Brown v. Presbyterian*

---

finance his personal lawsuit, but he has not disclosed any contributions. *See* Petitioners' Application to Extend Time to File Petition for a Writ of Certiorari at Appendix A.

[23] Petitioners did not consent to the filing of SSI's brief.

Healthcare Servs., 101 F.3d 1324, 1333 (10th Cir. 1996); *Mathews v. Lancaster Gen. Hosp.*, 87 F.3d 624, 635 (3d Cir. 1996); *Smith v. Ricks*, 31 F.3d 1478, 1485 (9th Cir. 1994); and *Doe v. La. Psychiatric Med. Ass'n*, No. 96-30232, 1996 WL 670414, at *3 (5th Cir. Oct. 28, 1996)).[24]

In assessing whether Petitioners had rebutted the presumption of immunity under Section 11112(a)(1), the Fifth Circuit again expressly followed the settled law:

> We begin with whether each peer review action was taken "in the reasonable belief that the action was in the furtherance of quality health care." It is plain that they were by the controlling standards. Other circuits have explained, as relevant under the facts of this case, that "[t]he 'reasonable belief' standard of the HCQIA is satisfied if the 'reviewers, with the information available to them at the time of the professional review action, would reasonably have concluded that their action would restrict incompetent behavior or would protect patients.'" "[T]he Act does not require that the professional review result in an actual improvement of the quality of health care," nor does it require that the conclusions reached by the reviewers were in fact correct. It bears emphasizing that "the good or bad faith of the reviewers is

---

[24] This Court denied certiorari in the *Bryan, Sugarbaker, Brown, Mathews,* and *Smith* cases.

> irrelevant"; rather it is an objective inquiry in which we consider the totality of the circumstances.

Pet. App. at 21a-22a (footnotes omitted).

Rejecting Poliner's flimsy arguments about Respondents' alleged subjective motives, the Fifth Circuit continued to follow the well-worn path of other circuits:

> Poliner's urging of purported bad motives or evil intent or that some hospital officials did not like him provides no succor. We have serious doubts that Poliner proved that the restrictions resulted from anti-competitive motives, and more to the point, the inquiry is, as we have explained, an objective one. Our sister circuits have roundly rejected the argument that such subjective motivations overcome HCQIA immunity, as do we.

Id. at 25a (footnote omitted).

Finally, in construing the "reasonable belief" standard in Section 11112(a)(4), the Fifth Circuit wrote:

> [W]e consider whether each peer review action was taken "in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts." "Our analysis under § 11112(a)(4) closely tracks our analysis under § 11112(a)(1)." In both instances, the temporary restrictions were "tailored to address the health care concerns" that had been raised – procedures

> in the cath lab – leaving untouched Poliner's other privileges. Nor was the information relayed to Knochel "so obviously mistaken or inadequate as to make reliance on [it] unreasonable." There was an objectively reasonable basis for concluding that temporarily restricting Poliner's privileges during the course of the investigation was warranted by the facts then known, and for essentially the reasons given above, we hold that Defendants satisfy this prong.

Id. at 35a-36a (footnotes omitted).

Faced with uniform precedent and the Fifth Circuit's unerring application of that precedent, Petitioners argue that the Fifth Circuit (and all other circuits) have incorrectly interpreted HCQIA's "reasonable belief" standard as an objective standard. Pet. 8. Petitioners reiterate and re-frame this single argument over the 34 pages of their Petition, asking this Court to overturn the Fifth Circuit's decision in this case, as well as to overrule all cases in other circuits that have interpreted HCQIA's "reasonable belief" standard.

In support, Petitioners mix federal and state peer review standards, cite *Black's Law Dictionary*, and weakly offer a confused hodgepodge of legislative history[25] and three quasi-policy arguments about alleged adverse "effects" of the application of the objective "reasonable belief" standard. Pet. at 12-32. None of Petitioners' arguments compels a departure from the uniform caselaw applying the plain language of the statute and clear Congressional intent.

---

[25] AAPS does not believe that examination of legislative intent is necessary. AAPS Br. at 7, 12.

On the legislative history, Petitioners suggest that Congress intended evidence of subjective intent (or perhaps just evidence of anticompetitive motive) to trump a determination of "reasonable belief" under HCQIA.[26] That suggestion, however, entirely disregards the Courts of Appeals' uniform analysis of that same legislative history and uniform conclusion that "HCQIA's 'reasonableness requirements were intended to create an objective standard of performance, rather than a subjective good faith standard.'" Pet. App. at 18a (footnote omitted – *quoting Bryan*, 33 F.3d at 1323).[27] Pointing to the same Committee report cited by many courts for the conclusion that Congress rejected a subjective standard and adopted instead an objective standard, Petitioners argue that, although Congress clearly favored an objective "reasonable belief" test, it did not preclude consideration of evidence of bias or improper motive. Pet. at 17-20.[28] Petitioners never deal with the irreconcilable difference between an objective standard and a subjective standard and never even hint how a court would begin to apply Petitioners' proposed hybrid standard that somehow combines objective reasonableness with subjective motivation. Petitioners' proposal is contrary to the statute and the legislative history, illogical, and, indeed, unworkable.

---

[26] Petitioners' focus on anticompetitive motive is particularly puzzling since Petitioners' antitrust claims were dismissed on summary judgment, and Petitioners have not challenged that dismissal.

[27] *Singh*, 308 F.3d at 32, 38-39; *Brader v. Allegheny Gen. Hosp.*, 167 F.3d 832, 840-41, 843 (3d Cir. 1999); *Mathews*, 87 F.3d at 634-36, 638; *Freilich v. Upper Chesapeake Health, Inc.*, 313 F.3d 205, 212-13 (4th Cir. 2002); *Imperial v. Suburban Hosp. Ass'n, Inc.*, 37 F.3d 1026, 1030 (4th Cir. 1994); *Meyers v. Columbia/HCA Healthcare Corp.*, 341 F.3d 461, 468-69, 471 (6th Cir. 2003); *Sugarbaker*, 190 F.3d at 912-14, 916-17; *Smith*, 31 F.3d at 1485; *Austin v. McNamara*, 979 F.2d 728, 734-35 (9th Cir. 1992); *Brown*, 101 F.3d at 1333; *Bryan*, 33 F.3d at 1323.

In further support of their legislative history argument, Petitioners cite (1) the title of Public Law 99-660, which includes the words "good faith" and (2) a statement related to the notice and hearing requirements for non-emergency professional review actions. Pet. at 18. The title of the act provides no guidance at all, and Petitioners' reference to a discussion of other portions of HCQIA which they do not challenge here sheds no light on the "reasonable belief" standard.

Petitioners then cite the dissent in *Austin v. McNamara*, 979 F.2d at 741 n.3, the first appellate case announcing the objective reasonableness standard. Pet. at 19-20 n.11. No Circuit Court has ever followed the dissent in *Austin*. To the contrary, the Circuits Courts, separately and collectively, have reached the same conclusion again and again: the "reasonable belief" requirement is an objective standard, not a subjective one. *See Singh*, 308 F.3d at 32; *Bryan*, 33 F.3d at 1323; *Sugarbaker*, 190 F.3d at 912; *Brown*, 101 F.3d at 1333; *Mathews*, 87 F.3d at 635; *Smith*, 31 F.3d at 1485. The Fifth Circuit's decision in this case simply reaches the inevitable result that Petitioners hoped to avoid.[29]

---

[28] Petitioners' argument seems to use the word "more" as its primary lynchpin. Pet. at 18.

Petitioners then argue that the Fifth Circuit's faithful application of the objective "reasonable belief" standard is bad policy that results in three adverse consequences: according to Petitioners, this standard, consistently applied by all of the federal Circuit Courts that have addressed it, "[u]surps the fact-finding role of the jury[, . . .] [r]enders state peer review immunity statutes meaningless[, . . . and t]ransforms the qualified immunity intended by Congress into absolute immunity[.]" Pet. at i-ii. On pages 21-22 of their Petition, Petitioners raise a fourth alleged adverse consequence – that no evidence can be used to rebut the presumption of immunity. This simply duplicates Petitioners' complaint that the courts have transformed HCQIA immunity from a qualified immunity to an absolute immunity.

---

[29] Petitioners offer no proof that Congress has disapproved of the federal courts' consistent interpretation of the "reasonable belief" standard in Sections 11112(a)(1) and (4) or has otherwise tried to amend the statute to "correct" the prevailing, unanimous construction of the statute.

Petitioners urge that the Court's application of an objective reasonableness standard wrongly usurps the jury's fact-finding role. Pet. 22-26. The same could be said of any case in which a trial or appellate court decides an issue as a matter of law. Petitioners' arguments prove too much and nothing at all. This argument reveals Petitioners' frustration with the Fifth Circuit's faithful application of existing law, but offers no viable reason to reverse the past decade and a half of uniform appellate court interpretations of HCQIA.[30] Moreover, this argument ignores the express intent of Congress that medical peer review cases almost always be decided as a matter of law. *See* H.R. Rep. No. 99-903, at 10 (1986), *as reprinted* in 1986 U.S.C.C.A.N. 6384, 6393.

Petitioners' claim that state peer review statutes have been rendered meaningless makes no sense. The state statutes complement HCQIA by providing different and independent grounds for immunity for peer reviewers: peer reviewers in Texas have immunity (1) under HCQIA when their actions are objectively reasonable and/or (2) under the Texas statute when they subjectively have no knowledge of the use of false information in the peer review process. *See* 42 U.S.C. § 11115(a) (expressly preserving other immunities provided by law). Indeed, the trial court in this case found, as a matter of law, that the suspension of Dr. Poliner's cardiac catheterization and echocardiography privileges in June 1998 was immune under both HCQIA and the applicable Texas statute. *See* Pet. App. at 94a-110a; *see also Maewal v. Adventist Health Sys./Sunbelt, Inc.*, 868 S.W.2d 886 (Tex. App. – Fort Worth 1993, writ denied) (construing and harmonizing Texas peer review statute and HCQIA). In Texas, a number of cases have separately considered the applicability of the Texas statute. *See, e.g., St. Luke's Episcopal Hosp. v. Agbor*, 952 S.W.2d 503 (Tex. 1997) (holding that Texas statute provides hospitals with immunity from negligent credentialing claims); *Dallas County Med. Soc'y v. Ubiñas-Brache*, 68 S.W.3d 31, 39-40 (Tex. App. – Dallas 2001, pet. denied) (holding that plaintiff-physician waived his claims by failing to request a jury question on malice under the Texas peer review statute); *Roe v. Walls Reg'l Hosp.*, 21 S.W.3d 647, 653-54 (Tex. App. – Waco 2000, no pet.) (holding that hospital was immune for peer review actions under Texas statute as a matter of law). Petitioners' unsubstantiated claims of preemption are simply wrong.[31]

---

[30] AAPS's odd, related complaint that the Fifth Circuit substituted its "(untrained) medical judgment" for the at least equally untrained medical judgment of the jury ignores the standards under Federal Rule of Civil Procedure 50, which the Fifth Circuit painstakingly applied. AAPS Br. at 3.

Finally, Petitioners warn that the immunity afforded by an objective "reasonable belief" test amounts to absolute immunity and betrays Congress's intent to create only a qualified immunity. Pet. 12-14, 15-17, 19-20, 30-32; *see also* AAPS Br. at 5. They also argue hyperbolically that the application of the objective reasonableness standard means that there exists no evidence that can rebut a presumption of immunity. Pet. 21.[32] Petitioners conveniently forget that a plaintiff need only rebut the presumption of immunity as to one of the four prongs of Section 11112(a) in order to defeat HCQIA immunity. Petitioners also conveniently ignore the handful of cases in which physician-plaintiffs have prevailed or defeated summary judgment. *See, e.g., Brown*, 101 F.3d at 1332-34; *Islami v. Covenant Med. Ctr., Inc.*, 822 F. Supp. 1361 (N.D. Iowa 1992); *see generally*, Scott M. Smith, Annotation, *Construction and Application of Health Care Quality Improvement Act of 1986*, 121 A.L.R. FED. 255 (1994 and Supp. 2004). These strawmen deserve no further discussion.[33]

---

[31] Additionally, the Texas statute, when met, provides protection from all civil liability, not simply from liability for damages.

---

[32] While Petitioners disagree, the Fifth Circuit thoroughly explained why, under settled law, Petitioners' specific claims about alleged Medical Staff Bylaws violations were not relevant to the HCQIA immunity analysis. Pet. at 21-22; *see* Pet. App. at 27a-29a.

[33] Amici attempt to raise additional, unfounded arguments that Petitioners do not raise and have never raised. The Court should not consider any of these late arguments, and these arguments fail on their merits in any event. For example, AAPS argues cursorily that "'[r]easonable belief' must include a subjective element to avoid constitutional difficulties." AAPS Br. at 17. SSI argues first that the Courts of Appeals, in interpreting HCQIA, have somehow "displaced" HCQIA with federal common law and also that HCQIA must now be interpreted

(Continued on following page)

Contrary to Petitioners' claims, the Fifth Circuit faithfully carried out the precise policy balance Congress struck in passing HCQIA. Pet. App. at 16a-17a, 28a-29a.

As the Court wrote:

> To allow an attack years later upon the ultimate "truth" of judgments made by peer reviewers supported by objective evidence would drain all meaning from the statute. The congressional grant of immunity accepts that few physicians would be willing to serve on peer review committees under such a threat; as our sister circuit explains, "'the intent of [the HCQIA] was not to disturb, but to reinforce, the preexisting reluctance of courts to substitute their judgment on the merits for that of health care professionals and of the governing bodies of hospitals in an area within their expertise.'" At the least, it is not our role to re-weigh this judgment and balancing of interests by Congress.

---

according to Joint Commission on Accreditation of Healthcare Organizations' ("JCAHO") standards. SSI's mangled, laborious efforts to manufacture a circuit split under the guise of federal common law fail – the cases in SSI's grab-bag either apply HCQIA's objective standards consistently to find immunity as a matter of law, discuss different state peer review immunity statutes that use subjective, not objective, standards, discuss immunity under medical staff bylaws provisions, or do not mention HCQIA at all. SSI gives no clue about how any JCAHO standards would make any difference in this case, even if they were applicable (which they are not).

Id. at 36a (footnote omitted – *quoting Lee v. Trinity Lutheran Hosp.*, 408 F.3d 1064, 1073 (8th Cir. 2005) (*quoting Bryan*, 33 F.3d at 1337)). Congress passed HCQIA to put an end to exactly the type of second-guessing of reasonable peer review decisions that Petitioners and AAPS urge here. *See, e.g.*, Pet. at 10-12; AAPS Br. at 11.

II. THE FIFTH CIRCUIT CORRECTLY APPLIED HCQIA IN REVERSING AND RENDERING JUDGMENT FOR RESPONDENTS.

The Fifth Circuit correctly applied the HCQIA immunity analysis, reversing the Amended Final Judgment and rendering judgment for Respondents. Reviewing the district court's denial of Respondents' motion for judgment as a matter of law *de novo* under the proper, well-established standard, Pet. App. at 16a-37a, the Fifth Circuit held that Respondents were "immune under HCQIA from money damages for the temporary restrictions of Poliner's privileges." Pet. App. at 3a.

Cognizant of the statutory presumption of immunity and the proper placement of the burden of proof, the Fifth Circuit first determined that, at the time of the professional review actions, the reviewers acted "in the reasonable belief that the action was in the furtherance of quality health care." 42 U.S.C. § 11112(a)(1). Citing opinions from many different circuits, the court concluded that, on May 14, and again on May 27, given Petitioner's alarming treatment of Patient 36 and the string of other patient-safety concerns that had surfaced "in relatively quick succession," "there was ample basis for concern" to support the temporary restriction of Poliner's cardiac catheterization privileges. Pet. App. at 23a. "[A]s to both peer review actions, the belief that temporarily restricting Poliner's cath lab privileges during an investigation would further quality health care was objectively reasonable." *Id.* Based on well-settled law, the Court of Appeals properly rejected Poliner's arguments for hindsight or post-hoc analysis and for consideration of subjective motives. *Id.* at 23a-25a; *see supra* at 16-27.

The Court of Appeals next held that no reasonable jury could have determined that Respondents failed to make "a reasonable effort to obtain the facts." 42 U.S.C. § 11112(a)(2). As to the May 14 abeyance, a review of the care that Poliner provided to Patients 3, 9, and 18 had been conducted, as had an initial review of Patient 36's films and chart. Pet. App. at 26a. As to the second abeyance, the 44 cases reviewed by the ad hoc committee constituted a reasonable investigation. Pet. App. at 26a-27a.[34]

Next, the Fifth Circuit held that the two abeyances complied with any required notice and hearing procedures under Section 11112(a)(3), together with Section 11112(c). Section 11112(c) modifies HCQIA's notice and hearing requirements for restrictions of clinical privileges that are imposed for no longer than 14 days while a peer review investigation is being conducted, 42 U.S.C. § 11112(c)(1)(B), and for restrictions imposed when there may be "an imminent danger to the health of any individual." 42 U.S.C. § 11112(c)(2); *see* Pet. App. at 30a. The Court concluded that the May 14 abeyance fell squarely within Section 11112(c)(1)(B) and that the extension of the abeyance fell squarely within Section 11112(c)(2). Pet. App. at 30a-31a. The gravity of Poliner's diagnostic error with Patient 36, the substandard care found to have been given in more than half of the cases reviewed, and the serious risks accompanying cardiac catheterizations supported the conclusion that Respondents' failure to extend the restrictions on Poliner's privileges "may [have] result[ed] in an imminent danger to the health of any individual." 42 U.S.C. § 11112(c)(2). Furthermore, and in the alternative, the court concluded that "Poliner received 'fair' procedures" under the circumstances in connection with the second abeyance. 42 U.S.C. § 11112(a)(3); *see* Pet. App. at 33a-34a.[35]

---

[34] Petitioners do not challenge the Fifth Circuit's holding that Respondents conducted a reasonable effort to obtain the facts under Section 11112(a)(2) as a matter of law.

Finally, undertaking its objective analysis for Section 11112(a)(4) – whether each of the peer review actions was taken "in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts" – the Court determined that the temporary restrictions were warranted. Pet. App. at 35a-36a.

---

[35] Again, Petitioners do not challenge the Fifth Circuit's holdings with respect to Sections 11112(a)(3) and 11112(c).

In sum, the Court correctly held:

> Not only has Poliner failed to rebut the statutory presumption that the peer review actions were taken in compliance with the statutory standards, the evidence independently demonstrates that the peer review actions met the statutory requirements.

Id. at 36a-37a.

III. ADDITIONAL, DISPOSITIVE LEGAL ISSUES, RECOGNIZED BUT NOT DECIDED BY THE FIFTH CIRCUIT, ALSO MAKE THIS AN INAPPROPRIATE CASE FOR THIS COURT TO REVIEW.

Though HCQIA immunity provided the sole basis for the Court of Appeals' reversal and rendition of judgment for Respondents, the Court recognized the existence of additional, dispositive legal issues that would require rendition of judgment for Respondents or, at a minimum, a new trial. Pet. App. at 37a.

Respondents will not detail or brief all of these additional arguments here, but simply indicate that their "other substantial arguments" include immunity under the Texas Medical Peer Review statute, Poliner's agreement to both abeyances, and other rendition points relating to all of Petitioners' state law claims. *Id.*[36] Respondents reserve the right to brief these points more fully, if necessary.

These other dispositive issues make this case a particularly poor vehicle for resolving the issue raised by Petitioners. For this additional reason, this Court should decline to review this case.

◆

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted,

THOMAS S. LEATHERBURY*
GABRIELA A. GALLEGOS
VINSON & ELKINS L.L.P.
2001 Ross Avenue
Suite 3700
Dallas, Texas 75201
(214) 220-7700

LEA F. COURINGTON
CURRAN TOMKO TARSKI LLP
2001 Bryan Street
Suite 2050
Dallas, Texas 75201
(214) 270-1400

Counsel for Respondents

December 12, 2008

**Counsel of Record*

---

[36] Respondents' separate new trial points include complaints about the sheer size of the verdict, repeated, improper argument appealing to passion and prejudice, and the erroneous admission and exclusion of critical evidence.

APPENDIX A

IN THE UNITED STATES DISTRICT COURT NORTHERN DISTRICT OF TEXAS DALLAS DIVISION

LAWRENCE R. POLINER, §
M.D., and LAWRENCE R. §
POLINER, M.D., P.A., §
§
Plaintiffs, §
§
v. §
§
TEXAS HEALTH SYS- §
TEMS, A TEXAS NON- § **NO. 3:00-CV-1007-P**
PROFIT CORPORATION §
d/b/a PRESBYTERIAN §
HOSPITAL OF DALLAS; §
JAMES KNOCHEL, M.D.; §
CHARLES LEVIN, M.D.; §
and JOHN HARPER, M.D., §
§
Defendants. §

AMENDED FINAL JUDGMENT

(Entered Nov. 20, 2006)

Pursuant to the Court's Memorandum Opinion and Orders of September 30, 2003, July 7, 2004, March 27, 2006, October 12, 2006, and November 17, 2006 and the jury verdict returned on August 27, 2004, the Court issues this Amended Final Judgment as follows:

1. Plaintiff Lawrence R. Poliner, M.D. ("Plaintiff") is awarded $22,500,000 on his defamation claim against Defendants Texas Health Systems d/b/a Presbyterian Hospital of

Dallas ("Presbyterian Hospital of Dallas") and Dr. James Knochel, M.D. ("Dr. Knochel").

2. Judgment is entered against Dr. Knochel as follows:
    a) $6 million for injury to Dr. Poliner's career;
    b) $6 million for Dr. Poliner's mental anguish; and
    c) $750,000 for punitive damages.
3. Judgment is entered against Presbyterian Hospital of Dallas as follows:
    a) $4.5 million for injury to Dr. Poliner's career;
    b) $4.5 million for Dr. Poliner's mental anguish;
    c) $750,000 for punitive damages.
4. Plaintiffs Lawrence R. Poliner, M.D. and Lawrence R. Poliner, P.A. (collectively, "Plaintiffs") take nothing from any Defendants based on Plaintiffs' antitrust claims.
5. Plaintiffs takes nothing from any Defendants based on Plaintiffs' Deceptive Trade Practices Act claims.
6. Plaintiffs take nothing from any Defendants based on Dr. Poliner's June 12, 1998 suspension.
7. Plaintiffs take nothing from any of their claims against defendants Charles Harris, M.D., Anthony Das, M.D., David Musselman,

M.D., Robert Brockie, M.D., Jorge Cherif, M.D., Steven Meyer, M.D., and Martin Berk, M.D.

8. Costs are assessed against Plaintiffs insofar as those costs were incurred defending those Defendants listed in Paragraph 7.

9. Costs are assessed against Defendants James Knochel, M.D. and Presbyterian Hospital of Dallas insofar as those costs were incurred prosecuting Plaintiffs' claims against said Defendants.

10. Prejudgment interest shall be awarded at the rate of 8.25% beginning from the date suit was filed through the date of judgment, October 13, 2006, applicable only to the amount of compensatory damages awarded.

11. Postjudgment interest shall be awarded at the rate of 4.90% beginning from the day after the date of judgment, October 14, 2006, until the judgment is satisfied.

IT IS SO ORDERED.

Signed this 17th day of November 2006.

/s/ Jorge A. Solis
JORGE A. SOLIS
UNITED STATES
DISTRICT JUDGE

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

LAWRENCE R. POLINER, §
M.D., and LAWRENCE R. §
POLINER, M.D., P.A., §
§
Plaintiffs, §
§ CIVIL ACTION NO.
v. § 3:00-CV-1007-P
§
TEXAS HEALTH SYSTEMS, §
A TEXAS NON-PROFIT §
CORPORATION d/b/a §
PRESBYTERIAN §
HOSPITAL OF DALLAS; §
JAMES KNOCHEL, M.D.; §
CHARLES LEVIN, M.D.; §
and JOHN HARPER, M.D., §
§
Defendants. §

MEMORANDUM OPINION AND ORDER

(Filed Nov. 17, 2006)

Now before the Court are the following motions filed by Defendants on October 27, 2006:

(1) Second Renewed Motion for Judgment as a Matter of Law;

(2) Second Motion for New Trial;

(3) Second Motion for Remittitur; and

(4) Motion to Alter or Amend Final Judgment.

After careful consideration of the briefing, the evidence, and the applicable law, the Court hereby DENIES Defendants' Second Renewed Motion for Judgment as a Matter of Law; DENIES Defendants' Second Motion for New Trial; DENIES Defendants' Second Motion for Remittitur; and GRANTS in PART and DENIES in PART Defendants' Motion to Alter or Amend Final Judgment.

SECOND RENEWED MOTION FOR JUDGMENT AS A MATTER OF LAW

Defendants filed a Rule 50(b) Renewed Motion for Judgment as a Matter of Law on October 3, 2005 following a jury verdict in this case. They now file a second Renewed Motion for Judgment as a Matter of Law. Because this Court already ruled on Defendants' post-verdict Rule 50(b) motion in its March 27, 2006 order, this motion is hereby DENIED as duplicative.

This motion is also DENIED on its merits. Defendants argue that the Court erred in ruling that Defendants waived their argument that Dr. Poliner's defamation claim was barred by limitations. Defendants argue, as they did in their original Rule 50(b) motion, that all statements relied on by Plaintiffs were made more than one year before this suit was filed. They also re-argue that any statements that do fall within the limitations period are nonactionable because they refer to the immune June 1998 summary suspension. Defendants argue for two pages that they raised their Rule 8(c) affirmative defense of statute of limitations at the pleading stage, at summary judgment, and at other various junctures throughout the case.

All of these arguments were raised and considered at length by the Court in the Rule 50(b) briefing and opinion. The Court acknowledged in its March 27, 2006 opinion that Defendants raised a Rule 8(c) affirmative defense of statute of limitations at the pleading and summary judgment stages. Apparently, Defendants do not understand the remainder of the Court's ruling. Again, the only bases Plaintiff had for defeating Defendants' statute of limitations argument were the two republications identified in the Court's order (*i.e.*, the December 14, 1999 Verification of Privileges letter and the January 5, 2000 credentialing application). The Court does not accept Defendants' contention that "the facts underlying the limitations defense were undisputed [and] did not require or warrant the submission of a separate jury question." (Mot. at 6 n.1.) The Court found at the summary judgment stage that these two republications were sufficient to raise a fact issue as to whether a defamatory republication was made within one year of filing suit. Defendants waived their statute of limitations defense with regard to those documents because they never argued at any time prior to their Rule 50(b) motion that those republication documents were insufficient to prove that a defamatory publication was made.[1] In sum, Defendants have not provided any legal basis or authority to cause the Court to reverse its earlier ruling. All of these arguments were reviewed and resolved in the Court's March 27, 2006 order denying Defendants' Renewed Motion for Judgment as a Matter of Law and therefore, Defendants' motion is hereby DENIED.

SECOND MOTION FOR A NEW TRIAL

Defendants argue that they are entitled to a new trial under Rule 59 because the jury was motivated by passion and prejudice. Because this Court already ruled on Defendants' motion for a new trial, which involved analysis of this particular issue, this motion is hereby DENIED as duplicative.

This motion is also DENIED on its merits. Defendants argue that the Court's October 13, 2006 order was "internally contradictory" because the "verdict cannot simultaneously be 'not reasonable' and 'not a rational amount' on the one hand, and yet be 'a product of reason' and 'resulting from a rational deduction,' on the other hand." (Mot. at 3.) Again, Defendants appear to have misunderstood the Court's ruling. The Court expressly stated that the verdict amount was not rational, but the jury's desire to punish Defendants was. There is no contradiction in these statements and the Court stands by its earlier ruling.

---

[1] Now, in addition to arguing that those republications referenced the summary suspension, not the abeyance, they argue the republications are nonactionable based on truth. For the same reasons, that argument has been waived.

Defendants also argue that the verdict amount was improperly based on damages evidence resulting from the June suspension. However, the jury was explicitly and properly instructed that it may only "consider damages, if any, that resulted from the actions of Defendants occurring on or before May 14, 1998 and/or May 29, 1998." The jury was instructed not to "consider damages that stem from any action taken on or after June 12, 1998." The Court presumes that the jury followed the instructions. As stated in the Court's October 13, 2006 order, the jury could have reasonably found that the evidence at trial established Dr. Poliner suffered economic damage and mental anguish as a result of being labeled a dangerous doctor. (Order at 10-11.)

In sum, Defendants have not provided any legal basis or authority to cause the Court to reverse its earlier ruling. All of these arguments were reviewed and resolved in the Court's October 13, 2006 order denying Defendants' first Motion for a New Trial and therefore, Defendants' second motion is hereby DENIED.

SECOND MOTION FOR REMITTITUR

Defendants file this Second Motion for Remittitur without providing any procedural basis therefore.

Because this Court already ruled on Defendants' original motion for remittitur, this motion is hereby DENIED as duplicative.

This motion is also DENIED on its merits. Defendants have not provided any basis under Rule 60 to warrant the Court granting relief from its order. First, Defendants argue the Court lacked any justifiable basis for declining application of the Maximum Recovery Rule. Defendants challenge the Court's determination that this case involved unique facts and circumstances that were not present in the controlling case law. Defendants vigorously argue that the Court was wrong in declining to find that this case and *Rea* are "fundamentally similar." This Court presided over *Rea* and has spent six years presiding over this case. The Court stands by its ruling.

Defendants' disagreement with the Court's analysis or conclusion does not entitle them to simply re-urge earlier arguments. Defendants have not provided any new legal authority or factual basis to warrant reversal of the Court's earlier ruling.

Defendants also argue that the Court's remitted award of compensatory and punitive damages remains excessive and that further remittitur is required. Defendants contend that the $21 million award has no basis in the evidence relating only to the abeyance. In its October 13, 2006 opinion, the Court discussed the evidence it relied on at length. (*See* Order at 9-12.) Moreover, as stated *supra*, there was evidence at trial establishing that Dr. Poliner suffered economic damage and mental anguish as a result of being labeled a dangerous doctor.[2]

Defendants also argue that the jury verdict awarded a double recovery because "[t]here is no reason to believe the jury followed the" instructions to award damages as to each individual defendant with regard to non-economic damages. (Mot. at 6 n.3.) The Court disagrees. The jury awarded a different amount next to each defendant's name, thereby giving reason to believe that the jury found different defendants liable for different amounts of Plaintiff's damages.

In sum, Defendants have not provided any legal basis or authority to cause the Court to reverse its earlier ruling. All of these arguments were reviewed and resolved in the Court's October 13, 2006 order entering a remittitur and therefore, Defendants' motion is hereby DENIED.

MOTION TO ALTER OR AMEND FINAL JUDGMENT

First, Defendants argue that Plaintiff Lawrence R. Poliner, P.A. is not entitled to recover judgment on a defamation claim it never brought. The Court agrees. The Final Judgment will be amended to reflect same. Likewise, the Court agrees that Plaintiff Lawrence R. Poliner, M.D. is not entitled to recover economic damages because all evidence of economic damages was suffered by the P.A. The Final Judgment will be amended to reflect same. Additionally, the Court will amend its Final Judgment to limit prejudgment interest to the amount of compensatory damages awarded.

---

[2] The Court will not engage in a discussion about whether Dr. Poliner's injuries were more or less horrific or painful than other injuries suffered by other victims in other cases unrelated to this one. The Maximum Recovery Rule applies to "factually similar cases" in the relevant jurisdiction.

The Court disagrees with Defendants' argument that the jury awarded double or overlapping recoveries. The jury was instructed to assess damages separately for each defendant. Additionally, as stated in the Court's October 13, 2006 order, the jury's finding of liability against the Hospital was appropriate in light of the testimony and conduct of the Hospital's Vice-President and President. That verdict does not overlap with its verdict against Dr. Knochel. Defendants' motion is denied on this basis.

With respect to Drs. Levin and Harper, the Court finds that because their settlement does not involve any appealable issue(s) and because Plaintiffs' claims against them were resolved by settlement and Order dated December 8, 2004, inclusion in the Final Judgment is neither necessary nor appropriate.

Therefore, Defendants' Motion to Alter or Amend Final Judgment is hereby GRANTED in part and DENIED in Part.

IT IS SO ORDERED.

Signed this 17th day of November 2006.

/s/ Jorge A. Solis
JORGE A. SOLIS
UNITED STATES
DISTRICT JUDGE

⑤

Supreme Court, U.S.
FILED
DEC 2 2 2008
OFFICE OF THE CLERK

No. 08-543

In the Supreme Court of the United States

LAWRENCE R. POLINER, M.D.,
LAWRENCE R. POLINER, M.D., P.A.,
Petitioners,
v.
TEXAS HEALTH SYSTEM, doing business as
Presbyterian Hospital of Dallas Texas, a Texas
non-profit corporation, JAMES KNOCHEL, M.D.,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

PETITIONERS' REPLY BRIEF

MICHAEL A. LOGAN
KARIN M. ZANER*
KANE RUSSELL COLEMAN & LOGAN PC
3700 THANKSGIVING TOWER
1601 ELM STREET
DALLAS, TX 75201
(214) 777-4200

**Counsel of Record*
Counsel for Petitioners

December 22, 2008

Becker Gallagher · Cincinnati, OH · Washington, D.C. · 800.890.5001

TABLE OF CONTENTS

Table of Authorities ii

Reasons for Granting the Writ 1

I. No Circuit Split Compels Review 1

  A. Of Three Possible Standards for the "Objectively Reasonable" Test, Only One is Correct. 2

  B. If the Second Standard is Correct, Review is Necessary. 3

  C. The Second Standard is Correct, Making the Third Erroneous. 4

  D. The Issue is of Great Importance. 6

  E. Respondents Dismiss the Alarming Effects. 7

II. The Fifth Circuit Sanitized the Facts 9

III. Other Issues in No Way Diminish Need for Review. 11

Conclusion 12

TABLE OF AUTHORITIES

CASES

Danforth v. Minnesota,
128 S.Ct. 1029 (2008) 3

Duncan v. Walker,
533 U.S. 167 (2001) 3, 4

RULES

Sup. Ct. R. 12 . . . . 3, 10

REASONS FOR GRANTING THE WRIT—REPLY TO OPPOSITION

I. No Circuit Split Compels Review

There is no circuit split. This is one of the few issues on which Respondents and Dr. Poliner agree.[1] Instead of precluding this Court's review of the case, the lack of a split only strengthens the compelling reason for this Court to grant certiorari. The gulf between the law created by Congress and its existing judicial construction is so gaping, it demands this Court's attention.

But, a more basic issue should first be addressed. Respondents acknowledge (again, consistent with Dr. Poliner) that the "plain language of the statute and clear Congressional intent" should control when courts examine the four prongs of HCQIA immunity and that it is not the Fifth Circuit's role to reweigh "the balancing of interests by Congress." *See* Opp. at 20 and 26 (internal citations omitted). From the content of Respondents' Opposition, it appears Dr. Poliner must clarify his argument as to the construction of

---

[1] Dr. Poliner also agrees that the documents included in Respondents' Appendix (the Amended Final Judgment dated November 20, 2006 and the Memorandum Opinion and Order dated November 17, 2006, Opp. App. 1-11) should be considered by the Court. Dr. Poliner appreciates Respondents including such documents (their omission was inadvertent), but maintains that these filings should be considered with the Final Judgment and the Memorandum Opinion dated October 13, 2006 (Pet. App. 38a-65a), especially given the numerous references made by the trial court to these documents in the amended final judgment and opinion.

Congress's "reasonable belief test" as well as why the current judicial construction (while uniform) is erroneous.

A. Of Three Possible Standards for the "Objectively Reasonable" Test, Only One is Correct.

There are three possible constructions for the "reasonable belief" test under the first and fourth prongs of section 11112(a): (1) a purely good faith or "subjective" test that inquires solely as to state of mind; (2) a "more" objective test that considers and weighs both objective and subjective motivations (but does not allow subjective motivations to trump objective motivations,[2] thus evaluating the totality of the circumstances surrounding the belief behind the peer review action[3]); and (3) a purely "objective" test that turns a blind eye to subjective intent. The first test (purely good faith) was rejected by Congress in favor of a "more objective" standard. The third "purely objective" standard is the one being judicially employed and is the standard urged by Respondents. *See* Opp. at 16-18.

---

[2] Contrary to Respondents' understanding of Dr. Poliner's position. *See* Opp. at 20.

[3] Respondents, the Fifth Circuit, and other courts assert that the "totality of the circumstances" should be considered. *See* Opp. at 17-18. How the "totality of the circumstances" can be analyzed when bad faith and malice are completely ignored is beyond reason.

B. If the Second Standard is Correct, Review is Necessary.

Respondents take the position that the lack of a split in the federal circuit courts on the question presented means this Court cannot grant the Petition. However, if the standard being uniformly applied by the courts is erroneous and obviously contrary to the plain meaning of the statute, the Court is not so constrained. The Court's task is to construe what Congress enacted, beginning with the language of the statute. *See Duncan v. Walker*, 533 U.S. 167, 172 (2001) (internal citations omitted). The Court has ample authority to control the administration of justice in the federal courts—particularly in their enforcement of federal legislation. *See Danforth v. Minnesota*, 128 S.Ct. 1029, 1046 (2008). If in fact the appropriate measure of "reasonable belief" under HCQIA immunity is the second "more objective" reasonable belief test, then the Court must correct the improperly stated rule of law that applies the third "purely objective" test, no matter how many courts have utilized this standard.[4]

---

[4] An improperly stated rule of law is grounds for the Court to accept certiorari as implied by Supreme Court Rule 12 (providing that a "petition for writ of certiorari is rarely granted when the asserted error consists of . . . the misapplication of a properly stated rule of law").

C. The Second Standard is Correct, Making the Third Erroneous.

The second "more objective" standard is far different from the third "purely objective" standard.[5] Dr. Poliner urges the Court to examine closely his argument in the Petition that the second "more objective" standard is correct. Dr. Poliner set forth for this Court the explicit statutory language of the first and fourth prongs of immunity. Pet. at 14-15. His detailed discussion of the statutory language, which Respondents fail to address much less even refute, reveals that the erroneous third standard applied by the courts gives the words "reasonable belief" (used in two of the four immunity prongs) no operative effect.[6] Analysis of the specific language stands alone without the need for any examination of Congressional intent.[7] But in the event more is needed, Dr. Poliner cites the legislative commentary behind HCQIA and the explicit

---

[5] Respondents correctly observe that the use of the term "more objective" by Congress is the primary lynchpin of Petitioner's argument. See Opp. at 21 n. 28. The language that Congress used to convey its intent is crucial to determining how to interpret the immunity it created. Its importance should be recognized, not marginalized.

[6] The Court has engaged in this same type of detailed analysis of statutory language, and is especially reluctant to construe a clause, sentence, or word as "surplusage," especially when it occupies a pivotal place in the statutory scheme. See *Duncan v. Walker*, 533 U.S. at 174-75 (internal citations omitted).

[7] Dr. Poliner agrees with the AAPS that an examination of legislative intent is not necessary, given the clear language of the term "reasonable belief" in the statute. *See* AAPS Br. at 7, 12 and Opp. at 19, n. 25.

Congressional references to anticompetitive motivations.[8] Pet. at 17-19. Dr. Poliner also specifically points to the Congressional history that makes it clear Congress wanted to "fill in the gap" for immunity where federal antitrust lawsuits circumvented state immunity laws, but did not want to override these laws. Pet. at 15-16. Dr. Poliner points to other places in the Congressional record (including the actual title of the bill—Encouraging Good Faith Professional Review Activities) that make it clear Congress did not intend for peer review resulting from bias, anticompetitive, and other subversive motivations to be immune. Pet. at 16-19. Dr. Poliner maintains that only one conclusion can follow—the second standard is correct and the third standard is erroneous.[9] And if Dr. Poliner is correct

---

[8] Defendants seem to confuse "anticompetitive motivations" with "antitrust claims." See Opp. at 20 n. 26. Given the onerous and complex body of law relating to antitrust claims (including the specific legal requirements that there exist an "antitrust injury" and plaintiff be an "efficient enforcer" of the antitrust laws), the fact that Dr. Poliner's antitrust claims were dismissed at summary judgment has no bearing on whether there existed "anticompetitive motivations" for his peer review actions. Instead, anticompetitive (also termed "economic") motivations are a type of subjective motivations (other types include personal and political motivations) and so can exist even though a valid legal antitrust claim may not.

[9] Without analysis of any real substance, Respondents claim the second standard is erroneous. In particular, Respondents state that "Petitioners' proposed hybrid standard that somehow combines objective reasonableness with subjective motivation" is "contrary to the statute and the legislative history, [and is] illogical." Opp. at 21. Dr. Poliner requests that the Court determine which standard (the second or the third) fits this description. Further, Dr. Poliner wholly disagrees with

(and this can only be determined if the Court accepts this case), then this is exactly the type of recurring judicial error the Court should address. Simply put, this Court is the only venue that can correct such a recurring judicial misinterpretation.[10]

D. The Issue is of Great Importance.

The Court thus faces the question of importance (i.e., whether there exist "compelling reasons" for this Court to exercise its "supervisory powers" to consider the merits of this case). Dr. Poliner described, throughout his Petition, the grave importance of this issue to his profession, the health care system, and patients themselves.[11] The amicus briefs filed by the AAPS and SSI (which are both physician groups) prove that this issue is of utmost concern to physicians across the country.[12] The fact that powerful groups

---

Respondents' claim on that same page that the standard is "unworkable." The fact that an immunity standard employed by the courts may not always result in favor of the defendants does not make the standard "unworkable." It instead makes it what it was intended by Congress to be—qualified immunity.

[10] Respondents appear to claim that Dr. Poliner should look to the legislative process instead of requesting certiorari from the Court. See Opp. at 4 and 22 n. 29. Dr. Poliner disagrees that the vital role of this Court should be diminished in this way. If the current judicial interpretation is erroneous and the issue is of great importance, this Court should step in irrespective of the status of legislative action or inaction.

[11] *See*, e.g., Pet. at 10-12 and 32-34.

[12] The articulation by these physician groups of the importance of qualified immunity in medical peer review and the devastating effects to the profession that have and will continue to occur if the

such as hospital associations and systems, insurance companies, and large hospitals[13] joined in an amicus brief supporting Respondents at the Fifth Circuit appellate level confirms that the HCQIA immunity issue raised by Dr. Poliner is an issue of national importance to hospitals, physicians, and patients.

Peer review is being soundly abused across the country under the guise of quality control. In some circumstances, it is being used as a weapon to silence whistle-blowing physicians or to quell economic threats.[14] This is a direct result of the flawed existing judicial construction of HCQIA immunity. If *Poliner* stands, abuse of peer review for malicious motives will remain unchecked and hospitals, health care systems, and those in control of the peer review system will act accordingly. Plainly, the question presented by Dr. Poliner is compelling and this Court's attention is overdue.

E. Respondents Dismiss the Alarming Effects.

In his Petition, Dr. Poliner details the specific devastating effects that the current judicial interpretation has on the medical profession and the medical peer review system as a whole. Respondents

---

Poliner case stands is essential to the Court's understanding of this matter. Although Dr. Poliner does not necessarily agree with the legal arguments contained in the amicus brief filed by SSI, Dr. Poliner will consent to the filing of the SSI's amicus brief as long as the Court considers the SSI's brief for this limited purpose only.

[13] *See* Opp. at ii-iii.

[14] For example, *see* AAPS Br. at 18-20.

merely skim the surface of these effects. For example, Respondents fail to address with any substance Dr. Poliner's clear arguments that the jury's fact finding role has been usurped in cases where immunity is not determined as a matter of law.[15] Respondents instead weakly conclude that the argument "proves too much and nothing at all" and merely repeat their reference to the "Fifth Circuit's faithful application of existing law."

As for Dr. Poliner's specific argument that state peer review laws have been rendered meaningless despite clear Congressional intent to the contrary, Respondents mischaracterize Dr. Poliner's argument as a preemption argument,[16] fail to provide any meaningful discussion regarding how state laws are being affected, and instead provide only superficial discussion of cases containing random analyses of Texas state immunity as proof that qualified peer review immunity under state law is alive and well in Texas.[17]

And as to Dr. Poliner's argument regarding the most alarming effect—that absolute immunity now exists—Respondents accuse Dr. Poliner of (among other things) being "hyperbolic" and "conveniently ignor[ing]" the handful of cases in which physician-plaintiffs have prevailed or defeated summary judgment." Opp. at 25. The "handful of cases" cited by Respondents (only two—*Brown* and *Islami*) are not ignored but are specifically discussed in Dr. Poliner's Petition. *Brown* focuses on the third prong as dispositive, making it inapposite to Dr. Poliner's argument. Pet. at 20 n. 12. *Islami* was a district court case that survived summary judgment as did *Poliner*, but had it been appealed, it would have likely suffered the same fate. Pet. at 25 n. 15. Using *Islami* as proof that the presumption of "reasonable belief" can actually be rebutted is simply laughable.[18]

---

[15] With their statement that immunity can "almost always be determined as a matter of law," Respondents admit that there will at least be some cases where the facts underlying the immunity determination are determined by a jury. *See* Opp. at 23.

[16] *See* Pet. at 27.

[17] Respondents wholly fail to address the scenario where malice is actually proven with the Texas cases they cite, which is the scenario in which the Texas immunity laws would be rendered ineffective and meaningless.

It is striking that Respondents never answer the crucial question posed on page 21 of Dr. Poliner's Petition—what type of evidence can be used to rebut the presumption of "reasonable belief"? Respondents' silence on this issue is deafening.

II. The Fifth Circuit Sanitized the Facts

Respondents claim that the Fifth Circuit correctly set forth the facts of the case and properly applied HCQIA immunity. But Respondents use the same sanitized version of the facts against which Dr. Poliner argues. They set forth a one-sided version of the medicine, which was the version that the federal court jury rejected. Respondents also recite "facts" (medical and otherwise[19]) in the Opposition that are simply not true or are misleading.

---

[18] The other citation, an ALR article lacking even a pinpoint cite, fails to furnish any cases holding a physician to be successful in rebutting the first and fourth prongs, as would be relevant to the issues at hand, making it a useless reference in this analysis.

Dr. Poliner purposefully did not address the factual details of the medical cases in his Petition, mindful that a "petition for writ of certiorari is rarely granted when the asserted error consists of erroneous fact findings. . . " Supreme Court Rule 12. However, to demonstrate to the Court that the "facts" stated in the Opposition and in the Fifth Circuit's opinion were clearly controverted at trial and not accepted by the jury, Dr. Poliner again refers to the specific yet concise descriptions of these medically complex interventional cardiology cases in the Petitioners' Appendix—the real story: Patient No. 10 (Pet. App. at 186a-187a); Patient No. 18 (Pet. App. at 189a-190a); Patient No. 9 (Pet. App. at 190a-191a); Patient No. 3 (Pet. App. at 191a-192a); Patient No. 39 (Pet. App. at 188a n.3); and Patient No. 36 (Pet. App. at 193a-196a). The facts relating to the May abeyances and the June summary suspension also are far different than Respondents' version (Pet. App. at 196a-202a).[20]

---

[19] Respondents' Opposition contains inaccuracies too numerous to address in this Reply. For example, Respondents claim that no economic damages were proven (*see* Opp. at 13) when in fact the jury findings clearly show that economic damages were found. *See* Pet. App. at 143a-144a, 158a. Further, Respondents' statement that Dr. Poliner's professional association "took in more than $1,200,000 in 2000" (*see* Opp. at 13 n. 19) is erroneous. To the contrary, the professional association had gross receipts of approximately $477,000, its income was $33,746, and wages to Dr. Poliner that year were approximately $34,000.

[20] Contrary to Respondents comments throughout the Opposition (Opp. at 8 n. 9, 10 n. 12, 14 n. 21, and 24), Dr. Poliner adamantly

Respondents' focus on the specific facts is a distraction. The question presented by this case does not hinge on its facts. Instead, it turns on an improper statement of the law by the Fifth Circuit—that an entire category of evidence should be wholly disregarded. Frankly, Respondents' recitation of the "facts" and its uncanny resemblance to those laid out it the Fifth Circuit's opinion only confirms Dr. Poliner's argument—that the Fifth Circuit wholly disregarded any and all evidence of subjective motivations and malice, blindly accepted Respondents' version of the "facts," and improperly sanitized the case.

III. Other Issues in No Way Diminish Need for Review.

Respondents urge the Court that the *Poliner* case is a "poor vehicle" given other grounds on appeal that could be dispositive of Petitioners' case. See Opp. at 30-31. These other issues were only briefly mentioned in passing by the Fifth Circuit. Respondents fail to establish precisely how these grounds preclude the Court's addressing the crucial question presented by Dr. Poliner. None of the other possible grounds alluded to by Respondents diminish the need for the Court to review the gravely erroneous judicial interpretation of HCQIA. Contrary to Respondents' claim, this case is not only a suitable vehicle, it is the

---

disputed the ad hoc committee findings and the June suspension through the entire administrative hearing and litigation processes, but chose to drop his cross-appeal only at the appellate level.

best case to raise the issue.[21] The *Poliner* case is uniquely poised for this Court's determination on an issue of great national importance to health care.

CONCLUSION

For the reasons stated above, this Court should grant the petition for a writ of certiorari.

Respectfully submitted,

KANE RUSSELL COLEMAN &
LOGAN PC

By: Michael A. Logan
Karin M. Zaner*
3700 Thanksgiving Tower
1601 Elm Street
Dallas, Texas 75201
Telephone: 214.777.4200
Facsimile: 214.777.4299

**Counsel of Record*
Counsel for Petitioners

Dated: December 22, 2008

---

[21] It is one of the very few, if not the only, case that has obtained factual findings by a jury of malice and behavior outside the HCQIA immunity standards.

113 ②

Supreme Court, U.S.
FILED
NOV 24 2008
OFFICE OF THE CLERK

No. 08-543

IN THE

Supreme Court of the United States

LAWRENCE R. POLINER, M.D., and
LAWRENCE R. POLINER, M.D., P.A.,

Petitioners,

v.

TEXAS HEALTH SYSTEM, doing business as
PRESBYTERIAN HOSPITAL OF DALLAS, TEXAS, a Texas
non-profit corporation, and JAMES KNOCHEL, M.D.,

Respondents.

On Petition for Writ of Certiorari to the
United States Court of Appeals for the Fifth Circuit

BRIEF OF *AMICUS CURIAE* ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, INC. IN SUPPORT OF PETITIONERS

ANDREW L. SCHLAFLY
939 OLD CHESTER ROAD
FAR HILLS, NJ 07931
(908) 719-8608

Counsel for Amicus

WILSON-EPES PRINTING CO., INC. – (202) 789-0096 – WASHINGTON, D. C. 20002

QUESTIONS PRESENTED

The Healthcare Quality Improvement Act of 1986, §402 *et seq.*, 42 U.S.C. §§ 11101 *et seq.* (2000) ("HCQIA") establishes limited immunity from money damages for professional review actions taken (1) in the reasonable belief that the action was in furtherance of quality health care, (2) after a reasonable effort to obtain the facts of the matter, (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirements of paragraph (3). A professional review action is presumed to have met these standards unless rebutted by a preponderance of the evidence. 42 U.S.C. § 11112(a) (2002).

The questions presented are:

1. Can a court exclude all evidence of subjective motives (an entire category of evidence) when it considers whether a defendant possessed a "reasonable belief" as required for HCQIA immunity under subsection (1) and (4), when such exclusion effectively:

    a) Usurps the fact-finding role of the jury?

    b) Renders state peer review immunity statutes meaningless?

c) Transforms the qualified immunity intended by Congress into absolute immunity?

2. What are the categories of evidence that can be considered in a court's determination of whether plaintiff's evidence is sufficient to rebut the statutory presumption?

TABLE OF CONTENTS

Pages

QUESTIONS PRESENTED i
TABLE OF CONTENTS iii
TABLE OF AUTHORITIES v
INTEREST OF *AMICUS CURIAE* 1
SUMMARY OF ARGUMENT 2
ARGUMENT 5
I. THE FIFTH CIRCUIT'S RELIANCE ON ITS OWN (UNTRAINED) VIEW OF UNREPRESENTATIVE MEDICAL CASES, WHICH WERE PROVEN TO BE THE PRODUCT OF BAD FAITH, IS PRECISELY WHAT HCQIA PROHIBITS 7
II. HCQIA'S REQUIREMENT OF A "REASONABLE BELIEF" IN FURTHERING QUALITY HEALTH CARE DOES NOT REQUIRE EXCLUSION OF ALL EVIDENCE OF BAD FAITH 12
A. The Plain Meaning of HCQIA Requires Subjective Belief as a Condition of Immunity 13
B. HCQIA's Legislative History Does Not Support Excluding and Ignoring Subjective Belief in Connection with Immunity 14
C. "Reasonable Belief' Must Include a Subjective Element to Avoid Constitutional Difficulties 17

III. EXTENDING IMMUNITY TO IMPROPER MOTIVES IN PEER REVIEW IS HAVING A CATASTROPHIC EFFECT ON THE PUBLIC INTEREST 18
CONCLUSION 20

TABLE OF AUTHORITIES

Pages

Cases

Austin v. McNamara, 979 F.2d 728 (9th Cir. 1992) .... *passim*

Bate Refrigerating Co. v. Sulzberger, 157 U.S. 1 (1895) 7

Bender v. Suburban Hosp., Inc., 758 A.2d 1090 (Md. Ct. Spec. App. 2000), *cert. denied*, 362 Md. 34, 762 A.2d 968 (2000) 17

Bryan v. James E. Holmes Reg. Med. Ctr., 33 F.3d 1318 (11th Cir. 1994), *cert. denied*, 514 U.S. 1019 (1995) 14

Edward J. DeBartolo Corp. v. *Florida Gulf Coast Building & Construction Trades Council*, 485 U.S. 568 (1988) 18

INS v. Cardoza-Fonseca, 480 U.S. 421 (1987) ... 12

Packard Motor Car Co. v. *NLRB*, 330 U.S. 485 (1947) 12

Poliner v. Texas Health Sys., 537 F.3d 368 (5th Cir. 2008). .... *passim*

Public Citizen v. United States Dep't of Justice, 491 U.S. 440 (1989) 17-18

Singh v. Blue Cross/Blue Shield of Mass., Inc., 308 F.3d 25 (1st Cir. 2002) 14

Stenberg v. Carhart, 530 U.S. 914 (2000) 2

Sugarbaker v. SSM Health Care, 190 F.3d 905 (8th Cir. 1999), *cert. denied*, 528 U.S. 1137 (2000) 14

Unexcelled Chemical Corp. v. *United States*, 345 U.S. 59 (1953) 12

United States v. *Sullivan*, 332 U.S. 689 (1948) 12

Statute and Legislative History

42 U.S.C. § 11112(a)(1) (HCQIA) .... *passim*
1986 Code Cong. & Admin. News 6392-93 15
H.R. Rep. No. 903, 99th Cong., 2d Sess. 10 15

Articles and Treatise

Roland Chalifoux, Jr., M.D., "So What Is a Sham Peer Review?", 7 *Medscape General Medicine* (No. 4) 47 (2005) 19
Jeff Chu, "Doctors Who Hurt Doctors," *Time* 52 (Aug. 15, 2005) 19
Lawrence Huntoon, M.D., Ph.D., "Sham Peer Review: The Unjust Objective Test," 12 *Journal of American Physicians and Surgeons* 100 (Winter 2004) 19
John F. Manning, "What Divides Textualists from Purposivists?," 106 Colum. L. Rev. 70 (2006) 14
John Minarcik, M.D., "Sham Peer Review: a Pathology Report," 9 *Journal of American Physicians and Surgeons* 121 (Winter 2004) 19
Caleb Nelson, "What Is Textualism?," 91 Va. L. Rev. 347 (2005) 14
William Parmley, "Clinical Peer Review or Competitive Hatchet Job," 36 *Journal of the American College of Cardiology* 2347 (2000) 19
Anthony W. Rodgers, "Comment: Procedural Protections During Medical Peer Review: A Reinterpretation of the Health Care Quality Improvement Act of 1986," 111 Penn St. L. Rev. 1047 (Spring 2007) 16
Norman Singer, Sutherland's Statutes and Statutory Construction 45.11 (5th ed. 1992) 18

William Summers, "Sham Peer Review: A Psychiatrist's Experience and Analysis," 10 *Journal of American Physicians and Surgeons* 125 (Winter 2005) 19

David Townsend, "Hospital Peer Review Is a Kangaroo Court," *Medical Economics* 133 (Feb. 7, 2000) 19

Steve Twedt, "The Cost of Courage: How the Tables Turn on Doctors," *Pittsburgh Post-Gazette* A1 (Oct. 26, 2003) 18

Gail Weiss, "Is Peer Review Worth Saving?", *Medical Economics* (Feb. 18, 2005) 18

John Zicconi, "Due Process or Professional Assassination?", *Unique Opportunities* (March/April 2001) 18-19

Internet

http://www.memag.com/memag/article/articleDetail.jsp?id=147405 (viewed 11/20/08) 18

http://www.post-gazette.com/pg/03299/234499.stm (viewed 11/20/08) 18

http://www.jpands.org/vol9no4/minarcik.pdf (viewed 11/20/08) 19

http://www.jpands.org/vol10no4/summers.pdf (viewed 11/20/08) 19

http://www.jpands.org/vol12no4/huntoon.pdf (viewed 11/20/08) 19

http://www.uoworks.com/pdfs/feats/PEERREVIEW.pdf (viewed 11/20/08) 19

No. 08-543

IN THE
Supreme Court of the United States

LAWRENCE R. POLINER, M.D., and
LAWRENCE R. POLINER, M.D., P.A.,

Petitioners,

v.

TEXAS HEALTH SYSTEM, doing business as
PRESBYTERIAN HOSPITAL OF DALLAS, TEXAS, a Texas
non-profit corporation, and JAMES KNOCHEL, M.D.,

Respondents.

*On Petition for Writ of Certiorari to the
United States Court of Appeals for the Fifth Circuit*

INTEREST OF *AMICUS CURIAE*[1]

The Association of American Physicians and Surgeons, Inc. ("AAPS"), founded in 1943, is a non-profit, national group of thousands of physicians.

---

[1] This brief is filed with the written consent of all parties, with timely notice provided in compliance with Rule 37.2(a) of the Supreme Court of the United States. Pursuant to its Rule 37.6, counsel for *amicus curiae* authored this brief in whole, and no counsel for a party authored this brief in whole or in part, nor did any person or entity, other than *amicus*, its members, or its counsel make a monetary contribution to the preparation or submission of this brief.

AAPS has members who have suffered from bad faith peer review by hospitals, also known as "sham peer review," as retaliation for practicing innovative medicine or standing up for patients. In many cases the sham peer reviews are initiated because a talented physician posed a competitive threat to colleagues who are influential at the hospital.

AAPS is dedicated to defending the practice of private and ethical medicine so that physicians may best serve their patients without interference by third parties. AAPS has filed *amicus curiae* briefs in numerous cases before the United States Supreme Court and federal Courts of Appeals, and its submissions have been cited in opinions. Submissions by AAPS have been cited by Justices on this Court. *See, e.g., District of Columbia v. Heller*, 128 S. Ct. 2783, 2860 (2008) (Breyer, Stevens, Souter and Ginsburg, JJ., dissenting); *Stenberg v. Carhart*, 530 U.S. 914, 933 (2000).

The issues presented in this case are of national importance, affecting virtually every hospital in the nation, every physician at those hospitals, and every one of their patients. *Amicus* has a direct and vital interest in these issues presented based on the harmful effect on the practice of medicine and the quality of patient care that results from judicially created – and statutorily unjustified – immunity for bad faith peer review.

SUMMARY OF ARGUMENT

The decision below is the latest – and most sweeping – of lower court rulings that increasingly misinterpret the federal statute governing hospital peer review known as The Healthcare Quality Improvement Act of 1986, §402 *et seq.*, 42 U.S.C. §§ 11101 *et seq.* (2000) ("HCQIA"). These decisions, and particularly the Fifth Circuit opinion below, substitute their (untrained) medical judgment and write the "reasonable belief" requirement of HCQIA out of the statute entirely. Review by this Court is essential to restore the plain meaning of "reasonable belief" to the federal statute.

The Fifth Circuit below opined at length about its own medical view of five cases handled by cardiologist Petitioner Lawrence Poliner, M.D., in reliance on the bad faith selection and presentation of these cases. In fact, there was nothing improper about Petitioner's care in any of these five cases, and the mischaracterization of medical cases is precisely what HCQIA prohibits. Respondents themselves had no genuine concern about these cases, as confirmed by the findings of the trial court based on exhaustive testimony. HCQIA requires a genuine concern or "reasonable belief" before smearing a physician, in order to prevent precisely the miscarriage of justice that occurred here. Dr. Poliner was absolved by the hospital of anything improper in these cases, and HCQIA precludes trumping up spurious charges to gain a competitive advantage. This Petition starkly illustrates the growing misapplication of HCQIA, and presents the best opportunity for this Court to correct it.

The Fifth Circuit ruled that evidence of malice and bad faith should be excluded from legal challenges to peer review, while simultaneously relying on the five medical cases selected and presented through malice and bad faith. Obviously cases selected and analyzed through bad faith are not credible evidence of the skills of a physician. It is illogical to exclude overwhelming evidence of bad faith and then insist on drawing conclusions from the product of that same bad faith. HCQIA expressly prohibits this unjustified approach, yet that is what the Fifth Circuit opinion and Respondents use as a legal standard.

In fact, evidence of malice and bad faith is a central element of the standard set by HCQIA, and immunity properly attaches to a peer review committee only if it acts in a "reasonable belief" of furthering quality patient care. *See* HCQIA, 42 U.S.C. § 11112(a)(1). The phrase "reasonable belief" in the statute could not be clearer. The "belief" in improving health care must exist - as opposed to bad faith - and it must be "reasonable". Immunity exists only if there is (i) a belief that patient care is being improved and (ii) such belief is reasonable. Immunity must not attach if either element is lacking. This statutory immunity is more than adequate for revoking the privileges of negligent physicians, and federal law does not support the *wrongful* destruction of a physician's career under the guise of peer review.

The precedent below, in giving hospitals nationwide a blank check to engage in malicious conduct, is untenable. The casualty is our nation's medical system and its ability to protect life, foster innovation, and benefit from competition. Physicians cannot innovate or speak out for patient care when it could cost them their career at the hands of a judicially protected bad faith peer review. Numerous articles, lawsuits and injustices including the case at bar are compelling illustrations of how hospitals exploit their immunity for sham peer review to intimidate or eliminate good physicians.

In this case the trial court found overwhelming evidence of bad faith in pressing a half-dozen cases against Petitioner, and the Fifth Circuit found no basis for overruling that central factual finding. Instead, the appellate decision simply excluded it and treated the cases as though they had been selected and analyzed in good faith:

> That Poliner had over 20 years of experience and an apparently clean record before these cases only serves to heighten the concern: why was this experienced physician now having these problems?

Poliner v. Texas Health Sys., 537 F.3d 368, 379 (5th Cir. 2008). But, as established by the trial court, there were no genuine "problems" or "concern", and the parading of these cases was a charade lacking in medical significance. HCQIA expressly forbids treating a bad faith peer review as though it were done in good faith, and then immunizing the harm done by it.

A grant of this Petition for Certiorari is essential to correct this error in statutory interpretation, which continues to spread at the expense of the integrity and quality of medical care.

ARGUMENT

An error in statutory interpretation in a split decision over a decade ago by the Ninth Circuit has gone uncorrected and spread for more than 15 years, causing expansive use of an incorrect judicial standard of absolute immunity for bad faith peer review by hospitals. Physicians who defend life, advance innovation, or stand up for patients, are intimidated, threatened, and often destroyed by self-serving wrongdoing by administrators, competitors, and adversaries. This is an epidemic of intimidating our finest and most ethical physicians, and restraining much-needed advances in medical care.

The root of this epidemic is a 2-1 decision by the Court of Appeals for the Ninth Circuit that downplayed the essential "belief" aspect of the "subjective belief" requirement. *Austin v. McNamara*, 979 F.2d 728 (9th Cir. 1992). There was no petition for certiorari pursued to reverse that decision, and it has since been reflexively repeated and expanded by lower courts. In this case the Fifth Circuit amplified this error by overturning a jury verdict where there was proven wrongdoing by defendants, and then entering judgment for the defendants without even granting a new trial. The result, if left unreviewed by this Court, is that hospitals will expect to receive immunity for wrongful, anti-competitive, and retaliatory peer reviews.

This precedent is catastrophic for medical care nationwide. Physicians are deterred from speaking out against hospital officials and competitors connected with the hospital. "Sham peer review" has become a powerful deterrent to improving quality of care. The interpretation that HCQIA immunity extends to improper motives is as harmful as it is legally unjustified. The courts below have converted the "reasonable belief" required by the statute into an "unreasonable rationalization that might be believed by others later." Legal immunity is thereby used to encourage improper motives and bad faith.

As the first Justice Harlan wrote for a unanimous Supreme Court over a century ago, where the statutory "language used is so plain and unambiguous," "a refusal to recognize its natural, obvious meaning would be justly regarded as indicating a purpose to change the law by judicial action based upon some supposed policy of Congress." *Bate Refrigerating Co. v. Sulzberger*, 157 U.S. 1, 36-37 (1895). Here the statutory language of HCQIA in requiring a "reasonable belief" is "so plain and unambiguous" as to require adherence to its textual meaning. Where, as here, the terms of the statute are clear, such terms should not be altered based on speculation about legislative intent.

I. THE FIFTH CIRCUIT'S RELIANCE ON ITS OWN (UNTRAINED) VIEW OF UNREPRESENTATIVE MEDICAL CASES, WHICH WERE PROVEN TO BE THE PRODUCT OF BAD FAITH, IS PRECISELY WHAT HCQIA PROHIBITS.

The five cases at the heart of the Fifth Circuit's decision below are medically insignificant and the proven result of bad faith in their selection, analysis and presentation. Their contrived nature is typical of bad faith peer reviews. Every cardiologist in the nation has inevitable complications in patients; every busy professional has less than a 100% success rate, particularly when failures of associates are included. HCQIA expressly forbids attaching immunity to a bad faith review, which inherently distorts the selection, analysis and presentation of a professional's work. The finest physician in the world could see his reputation and his career ruined if a bad faith reviewer were permitted with impunity to pick non-representative cases and present them in a malicious and distorted manner. Such "evidence" is thoroughly corrupted, and federal law denies immunity to those who attempt it. HCQIA does not condone the repeated smearing of a good physician – smearing that will likely continue with Respondents' filing with this

Court — based on cases of exaggerated significance that were selected in bad faith, as found by the jury below. (App. 132a-134a).

Yet AAPS has seen the same malicious tactic repeated again and again, and undoubtedly Respondents will use it here: rely on a few exaggerated and distorted cases *not* representative of the physician's practice, where fault lay elsewhere, and through bad faith smear the targeted physician. HCQIA prohibits this with its express requirement of a "reasonable belief" in furtherance of quality health care, as discussed in Point II below.

The five cases underlying the decision below illustrate how bad faith should never be protected with immunity. 537 F.3d at 370-71. These cases were frivolous at best, and were not selected and presented in an objective or good faith manner. A look at each case illustrates the contrivance.

The first case cited below (Patient 36) was a failure in the hospital's own equipment that prevented a perfect initial diagnosis, and the deceitful peer review shifted blame unjustifiably to Petitioner. The Fifth Circuit below had no justification for relying on its own (untrained) medical opinion about it as the basis for its decision. Without citation or basis in the record, the appellate court below blamed Petitioner for making a "diagnostic mistake." *Id.* at 370. Had this case been presented in good faith, the role of the faulty hospital equipment in causing this harmless error would have been clear. (App. 193a-194a, which cites to the record.) Regardless, Petitioner's care of the patient in this case was entirely proper, and the decision below does not state otherwise. *Id.* at 370-71. Giving such prominence to a case in which the care was entirely appropriate illustrates the inherent problem with relying on cases submitted in bad faith.

The four other cases trumpeted by Respondents, and at the foundation of the decision below, are even less significant. Patient 10 developed a mere rash after a procedure. The bad faith peer reviewers, and the appellate court, ascribed significance to this rash. *Id.* at 371 & n.7. In fact, the patient had exercised her right to refuse pre-treatment so as to prevent the rash. Petitioner did nothing wrong. The appellate court recognized this, and realized that the jury found bad faith by the reviewers in selecting and presenting these cases, App. 132a-134a, yet included the bad faith allegations as a basis for its judgment in favor of the hospital defendants. This is precisely what HCQIA prohibits by requiring proof of a "reasonable belief" in furtherance of quality care as a condition of ruling in favor of the peer reviewers.

Just as no statistician would take seriously a non-representative data sample, no court should apply HCQIA to cases that are the product of proven bad faith. Bad faith can easily mislead a court into thinking it is viewing something medically significant, when in fact it is nonsensical. The occurrence of a rash in a patient after a life-saving procedure performed by a cardiologist is not something to justify destroying his reputation, particularly when he had no fault for it.

The other patients' cases are likewise medically insignificant, yet the appellate court attached significance to them due to being misled by the bad faith behind the peer review. Patient 3 concerned Petitioner's reuse of a sheath site, a routine medical practice that was entirely justified. (App. 192a, which cites to the record.) No harm resulted to the patient, who was discharged in good condition, though this is omitted from the decision below. *Id.* at 371 & n.5. A common tactic in sham peer review is to present cases in which, unrealized by other reviewers and courts, the patient actually did perfectly well and there was no harm or risk of harm. The bad faith criticism is nothing more than biased speculation that is even disproven by the evidence.

Most sham peer reviews look for a patient who died and include that case, because its significance can be easily exaggerated to a layman. Virtually all cardiologists have patients who die, just as virtually all good trial lawyers have lost some cases. Patient 18 fit the bill here. She was 88 years old and went into cardiogenic shock *before* Petitioner's catheterization. A hospital committee performed its customary review and found that Petitioner's care was entirely appropriate, yet this was trumped up later for the bad faith peer review and repeated by the decision below. *Id.* at 371 & n.8; App. 189a-190a (which cites to the record).

Patient 9 was an elderly, hypertensive patient who had a stroke after Petitioner's procedure. No fault could be found with Petitioner's operation and, as recognized by the decision below, there was nothing Petitioner could have done to prevent the stroke; any mistakes were made by the nursing staff, not Petitioner. *Id.* at 371 & n.6.

Courts should not be misled by the distortions and omissions inherent in bad faith peer review, and this Court should clarify that HCQIA does not support the judiciary passing medical judgment on cases that are selected, analyzed, and presented in bad faith—or basically accepting the judgment asserted by the sham peer review without review or question. Respondents should not continue here to distort these cases, which were plainly selected and presented for the purpose of smearing Petitioner rather than advancing quality health care as mandated by HCQIA. Analyzing medical cases presented in bad faith is a fool's errand, and rubber stamping the corrupt prior review is worse. The proof of bad faith by the trial court below precludes the case-by-case inquiry at the core of Respondents' arguments and the appellate decision.

This Court should grant review here to end the judicial second-guessing of medical cases that are presented in bad faith as though they are significant, when in fact they are not. A harmless rash, an unpreventable death, inadequate hospital diagnostic equipment, and nursing staff errors should not be the basis for sweeping judgments in favor of the perpetrators of sham peer reviews against innovative and productive physicians. It thwarts the progress of medicine and contravenes the text of HCQIA to allow such bad faith to make a mockery of good medical practice.

In sum, the five cases at the heart of the decision below were plainly contrived: most consisted of patients who performed well, and included inevitable complications (like a rash) that were no fault of the targeted physician. Two of the cases, the elderly death and the supposedly incorrect diagnosis about an artery, are typical of sham peer review in inflaming a stronger reaction by a reviewer (including a court) than is warranted. Completely missing from these cases is any evidence that they were representative of the physician's overall practice. They were not. Yet these cases will undoubtedly be paraded by Respondents again before this Court in the hope of eliciting a layman's reaction, which is what a proper application of HCQIA would prevent.

II. HCQIA'S REQUIREMENT OF A "REASONABLE BELIEF" IN FURTHERING QUALITY HEALTH CARE DOES NOT REQUIRE EXCLUSION OF ALL EVIDENCE OF BAD FAITH.

The terms of HCQIA are clear: a reasonable "*belief*" that the peer review advances the quality of medicine is required before immunity can apply. 42 U.S.C. § 11112(a)(1) (emphasis added). This clear text of a statute trumps any speculation about legislative intent. "Judges interpret laws rather than reconstruct legislators' intentions. Where the language of those laws is clear, we are not free to replace it with an unenacted legislative intent." *INS v. Cardoza-Fonseca*, 480 U.S. 421, 452-53 (1987) (Scalia, J., concurring). *See also Unexcelled Chemical Corp.* v. *United States*, 345 U.S. 59, 64 (1953) (opinion of Douglas, J.); *United States* v. *Sullivan*, 332 U.S. 689, 693 (1948) (opinion of Black, J.); *Packard Motor Car Co.* v. *NLRB*, 330 U.S. 485, 492 (1947) (opinion of Jackson, J.) ("We are invited to make a lengthy examination of views expressed in Congress while this and later legislation was pending .... There is, however, no ambiguity in this Act to be clarified by resort to legislative history, either of the Act itself or of subsequent legislative proposals ....").

As demonstrated below, it was a reversible error for the court below to exclude an entire category of evidence about "belief" from this case. *See* 537 F.3d at 379-80.

A. The Plain Meaning of HCQIA Requires Subjective Belief as a Condition of Immunity.

The statutory term "reasonable belief" is not the same as "reasonable basis" or "improper belief but a proper result." Rather, the term "reasonable belief" must mean, first and foremost, a "belief" underlying the action. There is no justification for courts to look beyond this plain meaning and probe legislative history to alter it. After all, there is no legislative history for all the hundreds of Congressmen, many dozens of Senators, and President Ronald Reagan as to what they intended in enacting or signing this legislation. They would have probably pointed to the text itself, as courts should do.

Yet courts, most notably the lower court here and *Austin v. McNamara*, *supra*, failed to apply the text of "reasonable belief." The lower court incorrectly held that "bad faith is immaterial." *Id.* at 380 (quoting, *inter alia*, *Austin*). These precedents, grounded in the initial error of *Austin*, have read the "belief" aspect of the phrase entirely out of the law, and replaced it with a purely objective test to the exclusion of all evidence of the motivating belief. As fully described in the Petition, the jury found malicious intent and pervasive wrongdoing, App. 132a-134a, and the appellate court's own review of the medical records hardly justifies its statement that there were "legitimate concerns." *Id.* at 384. The concerns were *not* legitimate, and HCQIA does not provide immunity for illegitimate peer review.

Judge Pregerson was correct in dissenting from the *Austin* decision when he declared, "Evidence of motive and intent is relevant to show whether the defendants possessed a reasonable belief that [an adverse professional review action] was warranted by the facts known." 979 F.2d at 741 n.3 (Pregerson, J., dissenting). But other circuits, relying on the *Austin* majority, repeated its error. *See, e.g., Bryan v. James E. Holmes Reg. Med. Ctr.*, 33 F.3d 1318, 1335 (11th Cir. 1994), *cert. denied*, 514 U.S. 1019 (1995) ("The test is an objective one, so bad faith is immaterial."); *see also Singh v. Blue Cross/Blue Shield of Mass., Inc.*, 308 F.3d 25, 32 (1st Cir. 2002) (collecting cases); *Sugarbaker v. SSM Health Care*, 190 F.3d 905, 914 (8th Cir. 1999), *cert. denied*, 528 U.S. 1137 (2000) ("In the HCQIA immunity context, the circuits that have considered the issue all agree that the subjective bias or bad faith motives of the peer reviewers is irrelevant."). The decision below extends these erroneous precedents even further by overturning a jury finding of wrongdoing.

The Petition presents a manifest injustice resulting from allowing speculation about legislative intent to trump the statutory text itself. The Petition should be granted to enforce the text of HCQIA as it was written. *See generally* John F. Manning, "What Divides Textualists from Purposivists?," 106 Colum. L. Rev. 70 (2006); Caleb Nelson, "What Is Textualism?," 91 Va. L. Rev. 347, 349 (2005).

B. HCQIA's Legislative History Does Not Support Excluding and Ignoring Subjective Belief in Connection with Immunity.

The court below relied on precedents based on a misreading of the legislative history that began in *Austin v. McNamara*, where the split Ninth Circuit decision misconstrued the House Committee's desire for a "more objective" test as meaning an "only objective" test. "Our sister circuits have roundly rejected the argument that such subjective motivations overcome HCQIA immunity, as do we." *Poliner*, 537 F.3d at 379-80 (citing *Austin*). But the Fifth Circuit's exclusion of an entire category of evidence concerning intent and bad faith, no matter how egregious, rests on an erroneous interpretation of statutory history set forth in *Austin*:

> Initially, the [House] Committee considered a 'good faith' standard for professional review actions. In response to concerns that 'good faith' might be misinterpreted as requiring **only** a test of the subjective state of mind of the physicians conducting the professional review action, the Committee changed to a **more objective** 'reasonable belief' standard. The Committee intends that this test will be satisfied if the reviewers, with the information available to them at the time of the professional review action, would reasonably have concluded that their actions would restrict incompetent behavior or would protect patients.

979 F.2d at 734 (citing H.R. Rep. No. 903, 99th Cong., 2d Sess. 10, *reprinted in* 1986 Code Cong. & Admin. News 6392-93, emphasis altered). The *Austin* court failed to recognize that the Committee was merely rejecting an "only subjective" test, rather than eliminating any and all inquiries into subjective belief; the *Austin* court thereby created an incorrect "only objective" test that is increasingly exploited by sham peer review.

There is no need to consult the legislative history here, because the statutory text itself is clear. Moreover, the above legislative history does not support ignoring the subjective belief underlying the peer review. One commentator spotted the obvious flaw in the judicial elimination of a subjective test based on the legislative history:

> The legislative history of the HCQIA does not support this interpretation of the Act. Congress initially considered a good faith test; however, it was concerned that such a test would be "misinterpreted by courts as requiring only a test of the subjective state of mind" of the peer review committee members. Therefore, Congress adopted the "more objective 'reasonable belief' standard."

Anthony W. Rodgers, "Comment: Procedural Protections During Medical Peer Review: A Reinterpretation of the Health Care Quality Improvement Act of 1986," 111 Penn St. L. Rev. 1047, 1056 (Spring 2007) (citations omitted). The *Austin* Court overlooked how Congress intended that HCQIA encourage "good faith professional review activities of health care entities."

The reliance on legislative intent also omits what is strikingly absent from the legislative history: any indication that Congress sought to tilt the playing field in favor of unrestrained and unaccountable abuse of power by hospitals in eliminating innovative, competitive or outspoken physicians. Nothing in the legislative history even remotely supports the view that HCQIA could be applied to protect sham peer review, and it was reversible error for the Fifth Circuit to allow such use. Yet that is what has occurred by excluding all evidence of bad faith from judicial review of peer review actions.

Ignoring subjective belief is plainly contrary to the stated goal of the HCQIA: to advance the quality of medical care. Legitimate peer review is to improve patient care, not to advance improper motives of self-interest at a hospital. HCQIA requires "reasonable belief," and any "objective test" based on that standard must still require a legitimate belief. The appellate decision itself references the term "concern" nearly two dozen times, implying the necessity of a legitimate concern to justify hospital action. *See, e.g.*, 537 F.3d at 384 (citing "legitimate concerns" despite the finding of bad faith). But the jury found a lack of a legitimate concern, and the appellate court extended immunity to cover all bad faith in peer review. (App. 132a-134a.) This contravenes HCQIA.

C. "Reasonable Belief" Must Include a Subjective Element to Avoid Constitutional Difficulties.

In the absence of a subjective test, immunity has been applied to protect even discriminatory conduct during peer reviews. For example, a Maryland Court relied on *Austin* to hold that sexual discrimination by peer reviewers "which would be considered illegal in the context of employment [is] irrelevant when challenging a medical peer review process." *Bender v. Suburban Hosp.*, Inc., 758 A.2d 1090, 1100 (Md. Ct. Spec. App. 2000), *cert. denied*, 362 Md. 34, 762 A.2d 968 (2000). But a statutory grant of immunity to protect a discriminatory purpose would raise grave constitutional difficulties, and such interpretation of HCQIA to immunize discrimination should be avoided.

"It has long been an axiom of statutory interpretation that 'where an otherwise acceptable construction of a statute would raise serious constitutional problems, the Court will construe the statute to avoid such problems unless such construction is plainly contrary to the intent of Congress.'" *Public Citizen v. United States Dep't of Justice*, 491 U.S. 440, 466

(1989) (citing *Edward J. DeBartolo Corp.* v. *Florida Gulf Coast Building & Construction Trades Council*, 485 U.S. 568, 575 (1988)). Sutherland's Statutes and Statutory Construction recites that a "court should construe legislative enactments to avoid constitutional difficulties if possible" and that "when possible, statutory provisions should be construed in such a way as to avoid unconstitutionality." Norman Singer, Sutherland's Statutes and Statutory Construction 45.11, 48-49 n.4 & n.7 (5th ed. 1992).

Construing HCQIA to immunize bad faith, and even discriminatory intent, triggers constitutional issues of due process and equal protection. Such an interpretation should be rejected under the doctrine of constitutional avoidance.

III. EXTENDING IMMUNITY TO IMPROPER MOTIVES IN PEER REVIEW IS HAVING A CATASTROPHIC EFFECT ON THE PUBLIC INTEREST.

The judicially created federal immunity for bad faith in peer review has unleashed a national epidemic of sham peer review, at the expense of the public interest. *See, e.g.*, Gail Weiss, "Is Peer Review Worth Saving?", *Medical Economics* (Feb. 18, 2005);[2] Steve Twedt, "The Cost of Courage: How the Tables Turn on Doctors," *Pittsburgh Post-Gazette* A1 (Oct. 26, 2003);[3] John Zicconi, "Due Process or Professional Assassination?", *Unique Opportunities* (March/April

---

[2] http://www.memag.com/memag/article/articleDetail.jsp?id=147405 (viewed 11/20/08).

[3] http://www.post-gazette.com/pg/03299/234499.stm (viewed 11/20/08).

2001);[4] David Townsend, "Hospital Peer Review Is a Kangaroo Court," *Medical Economics* 133 (Feb. 7, 2000). Patients and the public suffer the most from the removal of competent and skilled physicians from the market, or their being deterred from competing.

For years the catastrophic nature of sham peer review has been recounted in medical journals. *See, e.g.*, William Summers, "Sham Peer Review: A Psychiatrist's Experience and Analysis," 10 *Journal of American Physicians and Surgeons* 125 (Winter 2005);[5] Roland Chalifoux, Jr., M.D., "So What Is a Sham Peer Review?", 7 *Medscape General Medicine* (No. 4) 47 (2005); John Minarcik, M.D., "Sham Peer Review: a Pathology Report," 9 *Journal of American Physicians and Surgeons* 121 (Winter 2004);[6] Lawrence Huntoon, M.D., Ph.D., "Sham Peer Review: The Unjust Objective Test," 12 *Journal of American Physicians and Surgeons* 100 (Winter 2004);[7] William Parmley, "Clinical Peer Review or Competitive Hatchet Job," 36 *Journal of the American College of Cardiology* 2347 (2000).

Hospitals and their favorite physicians are motivated by money just like everyone else, and if they enjoy immunity to eliminate competitors who impinge on their income, then they will do precisely that. *See, e.g.*, Jeff Chu, "Doctors Who Hurt Doctors," *Time* 52 (Aug. 15, 2005) ("Th[e] system is too open to manipulation and needs reform, says the 4,000-member American Association [sic] of Physicians and

---

[4] http://www.uoworks.com/pdfs/feats/PEERREVIEW.pdf (viewed 11/20/08).

[5] http://www.jpands.org/vol10no4/summers.pdf (viewed 11/20/08).

[6] http://www.jpands.org/vol9no4/minarcik.pdf (viewed 11/20/08).

[7] http://www.jpands.org/vol12no4/huntoon.pdf (viewed 11/20/08).

Surgeons."). Patients and the public interest suffer most when physicians are deterred by sham peer review from advancing quality medical care.

If a physician were truly a danger to patients, then the state medical board would restrict or revoke his medical license. Patients would abandon such a physician, just as shoppers will not continue buying bad products. Or if a hospital wants to rid itself of a negligent physician, then it may do so regardless of whether it has special immunity under federal law. But immunity for wrongful acts is misplaced.

Judicial construction of HCQIA to grant immunity to hospitals for bad faith peer review has caused an epidemic of abuse, now greatly magnified by the decision below.

CONCLUSION

This Court should grant the Petition for *Writ of Certiorari.*

Respectfully submitted,

ANDREW L. SCHLAFLY
939 OLD CHESTER ROAD
FAR HILLS, NJ 07931
(908) 719-8608

Counsel for Amicus

Dated: November 21, 2008

Supreme Court, U.S.
MOTION FILED

NOV 24 2008

William K. Suter,
Clerk

(3) 113

No. 08-543

IN THE

Supreme Court of the United States

LAWRENCE R. POLINER, M.D., AND
LAWRENCE R. POLINER, M.D., P.A.,
Petitioner,

v.

TEXAS HEALTH SYSTEM, DOING BUSINESS AS
PRESBYTERIAN HOSPITAL OF DALLAS, TEXAS, A TEXAS
NON-PROFIT CORPORATION, AND JAMES KNOCHEL, M.D.,
Respondent.

**On Petition for a Writ of Certiorari to the
United States Court of Appeals
for the Fifth Circuit**

MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* AND BRIEF OF *AMICUS CURIAE* SEMMELWEIS SOCIETY INTERNATIONAL, INC.

PAUL S. BLUMENTHAL *
JEFFREY GRASS
Of Counsel
LAW OFFICE OF PAUL S.
BLUMENTHAL, P.A.
Suite 301, West Court Building
2448 Holly Avenue
Annapolis, MD 21401
(410) 266-2430

* Counsel of Record

November 24, 2008

WILSON-EPES PRINTING CO., INC. – (202) 789-0096 – WASHINGTON, D. C. 20002

IN THE

Supreme Court of the United States

No. 08-543

LAWRENCE R. POLINER, M.D., AND
LAWRENCE R. POLINER, M.D., P.A.,
Petitioner,

v.

TEXAS HEALTH SYSTEM, DOING BUSINESS AS
PRESBYTERIAN HOSPITAL OF DALLAS, TEXAS, A TEXAS
NON-PROFIT CORPORATION, AND JAMES KNOCHEL, M.D.,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE*

COMES NOW, SEMMELWEIS SOCIETY INTERNATIONAL, INC., by and through counsel and files this its Motion to File Amicus Curiae Brief without the consent of the Petitioners to this matter.

Respectfully submitted,

PAUL S. BLUMENTHAL *
JEFFREY GRASS
Of Counsel
LAW OFFICE OF PAUL S.
BLUMENTHAL, P.A.
Suite 301, West Court Building
2448 Holly Avenue
Annapolis, MD 21401
(410) 266-2430

* Counsel of Record

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES iv

INTEREST OF *AMICUS CURIAE* 1

ISSUES PRESENTED 3

BACKGROUND OF PHYSICIAN DUE PROCESS ISSUES 4

ARGUMENT 9

I. The Court Should Grant The Petition To Resolve Whether The Health care Quality Improvement Act Has Been Displaced By Federal Common Law 9

II. Medicare Improvements for Patients and Providers Act of 2008, Requires A Shift In Interpreting HCQIA's Fairness And Due Process Standards For Peer-Reviewed Physicians. After July 2008, HCQIA Must Be Interpreted According To JCAHO Standards Issued And Enforced Pursuant To Express Statutory Delegation to JCAHO From The Secretary Of Health And Human Services 18

III. HCQIA's Due Process, Evidentiary, and Related Fairness Requirements 18

CONCLUSION 24

APPENDIX A - *The "White Coat" of Silence* Working Nurse Magazine. *Reporting suspicions to the charge nurse is often enough to get marked as a troublemaker and potential victim of the kill the messenger syndrome.* (Feb 21, 2005 pages 11-15.) 1a

TABLE OF CONTENTS—Continued

Page

APPENDIX B - SILENCE KILLS NEWS RELEASE *New Study Finds U.S. Hospitals Must Improve Workplace Communication to Reduce Medical Errors, Enhance Quality of Care.* (January 26, 2005) 8a

APPENDIX C - HEALTHGRADES NEWS-RELEASE - *DEATH RATE 70% LOWER AT NATION'S TOP-RATED HOSPITALS: HEALTHGRADES 11TH ANNUAL HOSPITAL QUALITY STUDY.* GOLDEN, Colo. (October 14, 2008) 12a

APPENDIX D - *FIVE YEARS AFTER TO ERR IS HUMAN: WHAT HAVE WE LEARNED?* Journal of the American Medical Association (JAMA) (Mar. 18, 2005) 17a

APPENDIX E - JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS (JCAHO) . . . *[t]hese standards are "the law of the land"*. . . (Oakbrook Terrace, Ill. - April 30, 2001)......... 23a

APPENDIX F - JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS (JCAHO) *Applicable Joint Commission Standards (LD.03.01.01 and LD.03.01.01)* Behaviors that Undermine a Culture of Safety. (July 9, 2008) 27a

APPENDIX G - *Swinging Pendulum of Peer Review Immunity.* By Charles I. Artz, Esq. Physician's News Digest – Published November2001 *http://www.physiciansnews.com/law/1101.htm* 31a

TABLE OF CONTENTS—Continued

Page

APPENDIX H - OVERTREATED - *Why* Too Much Medicine Is Making Us Sicker and Poorer (Paperback ISBN-10: 1-58234-579-1 ISBN- 13: 978-1-58234- 579-6) Copyright © 2007 by Shannon Brownlee 40a

TABLE OF AUTHORITIES

CASES Page

Austin v. McNamara, 979 F.2d 728, 733 (9th Cir. 1992) 12
Bhatt v. Brownsville General Hosp., 236 Fed. Appx. 764 (3rd Cir. 2007) 12
Bolt v. Halifax Hosp. Med. Ctr., 891 F.2d 810, 821 (11th Cir.) 14
Bryan v. James E. Homes Reg'l Med. Ctr., 33 F.3d 1318, 1326-1329 (11th Cir. 1994) 14
Braswell v. Haywood Regional Medical Center, 234 Fed. Appx. 47 (4th Cir. 2007) 12
City of Milwaukee v. Illinois, 451 U.S. 304, 317 & n.9, 315 n.8 (1981) 10
Estate of Blume v. Marian Health Center, 516 F.3d 705 (8th Cir. 2008) 14
Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 108 (1989) 10
Freilich v. Upper Chesapeake Health, F.3d, 205 (2002) 13
Gordon v. Lewiston Hosp., 423 F.3d 184 (3rd Cir. 2005) 12
Illinois v. Outboard Marine Corp., 680 F.2d 473, 478 (7th Cir. 1982) 10
Imperial v. Suburban Hosp. Ass'n, Inc., 37 F.3d 1026, 1030 (4th Cir. 1994) 17
Lee v. Trinity Lutheran Hosp., 408 F.3d 1064 (8th Cir. 2005) 14
Meyers v. Columbia/HCA Healthcare Corp., 341 F.3d 461, 468 (6th Cir. 2003).. 13
Pegram v. Herdrich, 530 U.S. 211, 120 S.Ct. 2143, 2149 (2000) 2

Page

Poliner v. Texas Health Systems, 537 F.3d 368 (5th Cir. 2008) 2, 15

Resolution Trust Corp., v. Frates, 52 F.3d 295, 297 (10th Cir. 1995) 10

Resolution Trust Corp. v. Miramon, 22 F.3d 1357, 1360 (5th Cir. 1994) 10

Sugarbaker v. SSM Health Care, 190 F.3d 905, 912 (8th Cir. 1999) 16

Talwar v. Catholic Healthcare Partners, 258 Fed. Appx. 800 (6th Cir. 2007) 13

United States v. Oswego Barge Corp., (In re Oswego Barge Corp.), 664 F.2d 327, 335 (2d Cir. 1981) 10

Vistein v. American Registry of Radiologic Technologists, 509 F.Supp.2d 666 (N.D.Ohio.E.Div., 2007) 13

Xin Liu v. Amway Corp., 347 F.3d 1125, 1133 n.6 (9th Cir. 2003) 11

STATUTES

Health Care Quality Improvement Act of 1986 ["HCQIA"] Pub. L. No. 99-660, at 42 U.S.C. §§ 11101-11152 (1988) 2

H.R.Rep.No. 903, 99th Cong., 2d Sess. 9, *reprinted in* 1986 U.S. Code Cong. & Admin.News 6391 11

1965 (42 USC § 1395bb) 19

1986 U.S. Code Cong. & Admin.News 6392-93) 11

SCHOLARLY AUTHORITY Page

Charles I. Artz's, *Swinging Pendulum of Peer Review Immunity* (App. G) 7
JCAHO Bulletin, "Behaviors that Undermine a Culture of Safety," (July 9, 2008). 7
Lucian Leape , To Err Is Human, Institute of Medicine (2000) 8
Lisa Sprague, *Hospital Oversight in Medicare: Accreditation and Deeming Authority, National Health Policy Forum*, NHPF Issue Brief No. 802/May 6, 2005, p.4 22
Michael Myers, 51 S.DAK.LAWREV 465 (2006) 5
Shannon Brownlee, Overtreated (2007) 8, 9
Van Geertruyden: *Fox in the Henhouse* (2000) 4

IN THE

Supreme Court of the United States

No. 08-543

LAWRENCE R. POLINER, M.D., AND
LAWRENCE R. POLINER, M.D., P.A.,
Petitioner,

v.

TEXAS HEALTH SYSTEM, DOING BUSINESS AS
PRESBYTERIAN HOSPITAL OF DALLAS, TEXAS, A TEXAS
NON-PROFIT CORPORATION, AND JAMES KNOCHEL, M.D.,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF OF *AMICUS CURIAE* SEMMELWEIS SOCIETY INTERNATIONAL, INC.

INTEREST OF *AMICUS CURIAE*

Amicus SEMMELWEIS SOCIETY INTERNATIONAL, INC. (SSI) is a non-profit organization of physicians, nurses, and healthcare professionals. SSI's mission is to promote better-safer-less-costly healthcare for all Americans.[1]

SSI encourages healthcare professionals to work conscientiously for patients' welfare and safety, and to advocate for appropriate patient treatments, even when pressured by hospitals and physician-colleagues to over-or-undertreat patients. When doctors, nurses, and technicians are effectively shielded from retaliation, on-site professionals can follow their ethical duties and put the patient first. Now, per *Poliner v. Texas Health Systems,* 537 F.3d 368 (5th Cir. 2008), the Health Care Quality Improvement Act (42 U.S.C. § 11111 et seq. (1986)(HCQIA)), empowers management to openly retaliate against conscientious physicians without accountability.

---

[1] No contributions by parties.

This Court ruled in *Pegram v. Herdrich*, 530 U.S. 211, 219-220 (2000), that physicians are expected to ignore pressures to undertreat patients and provide "covered services with a reasonable degree of skill and judgment in the patient's interest." *Pegram* involved financial incentives if physicians delayed tests, but *Poliner* takes *Pegram* to extremes by expecting physicians to serve patients' best interests after stripping away doctors' few remaining HCQIA protections against badfaith peer-review.

Departing from prevailing interpretations by other federal circuits (see below), *Poliner* allows unprecedented use of medically questionable evidence to proclaim peer-reviewers' actions immune from damages. Presbyterian's peer-review actions against Dr. Poliner were held "objectively reasonable," even though the jury specially found that peer-reviewer malice and badfaith drove the adverse actions. Yet the Fifth Circuit overruled the jury, affirming peer-reviewers' badfaith actions as "objectively reasonable" (*Poliner v. Texas Health Systems* 537 F.3d at 379-380, 384-385).

ISSUES PRESENTED

Amicus requests consideration of three related issues.

1. Because *Poliner* interprets HCQIA's "objectively reasonable test" for peer-reviewer immunity contrary to several other circuits by substituting common law fiat for clearly worded statutory and legislative intent, ought this Court resolve the conflicts?
2. For the great majority of hospitals who elect Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation as final federal certification to deem them compliant with MEDICARE Conditions-of-Participation (CoP) and automatically eligible for MEDICARE payments, are JCAHO accreditation standards binding regulations governing patient care and peer-review for clinical privileging?
3. Because the *Poliner* decision was only eight days after Congress declared on July 15, 2008 that JCAHO had "unique deeming authority" to certify and deem hospitals MEDICARE-compliant, which precluded the Fifth Circuit's considering how JCAHO standards for peer-review proceedings may regulate clinical privileging by suffusing HCQIA's fairness and due process guarantees for peer-reviewed physicians, should the decision-timing issue be consolidated with this Court's determining how HCQIA ought to be interpreted?

BACKGROUND OF PHYSICIAN DUE PROCESS ISSUES

Besides stopping physicians from monitoring patient care and safety, *Poliner* has silenced those best situated to report healthcare overtreatment and MEDICARE fraud. Doctors rarely talk about it, but they all know what happens if they question or report billings for unnecessary treatment or other MEDICARE fraud.[2]

Michael J. Myers, healthlaw and healthcare business administration professor, spent 17 years as counsel and CEO of nonprofit hospitals before returning to university. He understands the organizational and financial forces driving healthcare. In March 2008 (four months before the *Poliner* decision), Myers gave an example from a hospital operated by the Mayo Clinic.

> [T]he fundamental corporate restructuring the United States healthcare system has undergone, since the enactment of HCQIA . . . [has] implications for physicians who now overwhelmingly are "employees" of large, integrated, and economically and politically influential healthcare systems. We should dwell upon the influence of such corporate integration upon physician behav-

---

[2] Yann Van Geertruyden, in *The Fox Guarding The Henhouse: How The Health Care Quality Improvement Act of 1986 and State Peer Review Protection Statutes Have Helped Protect Bad Faith Peer Review In the Medical Community, 18 J.Contemp.Health Law 239 (2001), told Alan Ullberg how his physician-father suffered badfaith peer-review when he refused to join a medical group; a family experience that informed the son of badfaith peer-review (and too-credible threats of it) as the "problem in the medical profession which is known by many, but spoken of by few."*

> ior and increased risk for a physician who does not adhere to the clinical and financial forces that drive system profitability. Last semester I had a former Mayo pediatric oncologist confirm how corporatization of Mayo has affected clinical judgment and [physician] autonomy. The employed physician who suggests that certain diagnostic and surgical procedures may be unnecessary and not in the best interests of patient care may be frustrating utilization targets and undermining the "production" incentives found in the contracts of employed physicians. The CEO/CFO and Medical Director will likely be offended with such conduct, as will fellow physicians who stand to profit from increased "clinical production."[3]

Poliner heightens what Professor Myers calls the "... increased risk for a physician who does not adhere to the clinical and financial forces that drive system profitability." Since *Poliner*, any evidence hospital managers put in the record that indicates a targeted physician may have provided substandard patient care, will support a peer-review action even if the fact finder establishes malice and badfaith.

A physician can win at trial only to have an appellate court cherry pick evidence from the record to make its *de novo* finding of "objective reasonableness." Affirming badfaith peer-review actions plays right into the hands of the managers of hospitals, profit and nonprofit, increasingly driven by the bottom line,[4]

---

[3] E-mail to Alan Ullberg from Professor Myers, March 25, 2008, in Ullberg's files.

[4] Michael Myers, 51 S.Dak.L.Rev. 465, 466 (2006), commenting how nonprofit regional hospitals "typically enjoy oligopolistic

Doctors are human. They make mistakes just like everyone who drives a car. It is well known among police officers that closely observing any driver will reveal a continuous series of inconsequential technical infractions. A trained police officer can appear in court and present his observations as "key evidence" to support a judgment of "safety risk." A reviewing court will likely affirm the trial court's judgment based on that finding. Under this scenario, any driver can be adjudicated "unsafe," just like any physician can be adjudicated a patient-safety risk.[5]

The Fifth Circuit's extreme standard for HCQIA judicial review allows an appellate court of lay judges, not trained in medicine, to make medical judgments. Judges affirm and immunize medically sloppy, bad-faith peer-review actions driven by malice, which can destroy a physician's reputation and career for being human. Handpicked "evidence" from the record sustains peer-reviewers' malicious actions as "objec-

---

market power in a region . . . [so] physicians, executives, board members, and their aligned business interests are able to place private interests ahead of their presumed public interest without significant risk of detection or penalty. These modern, multi-billion-dollar health systems earn revenues . . . to accommodate their collective interests, attracting an array of entrepreneurial constituents because, to quote bank robber Willie Sutton, that is 'where the money is.' . . . These . . .are bottomless, in part, because of the conflicts between the stated missions of hospital systems and their actual performance in the market."

[5] Shannon Brownlee, Overtreated: Why Too Much Medicine Is Making Us Sicker and Poorer (2007), quoting a surgeon that "good doctors make mistakes too. . . .[E]very physician is destined to make at least one horrible mistake in the course of a career—and most will carry the memory and shame of it for the rest of their lives." (p. 53).

tively reasonable." The kangaroo court-type peer-review affirmed in nearly all HCQIA cases is completely different from the "Objective, evidence-based decisions regarding appointment to the membership on the medical staff," that JCAHO standards prescribe.[6]

Officers and members of SSI attest that, in less than four months, "*The Poliner Principle: "Any evidence of bad medicine, no matter how contrived or flimsy, will support badfaith peer-review actions that are totally unaccountable,*" has chilled the medical community.

There is even less chance than before *Poliner* that those few doctors who might have broken their silence to save a patient from death or serious injury[7] will take the ultimate risk of career and medical license to save a patient's life.[8]

SSI fully supports goodfaith peer-review. Being human, physicians can become impaired, disruptive, or lose their medical skills. But *Poliner* allows all physicians to be smeared as "unsafe," "impaired," or

---

[6] In a July 09, 2008 bulletin, *Applicable Joint Commission Standards (see Appendix ______,* JCAHO describes generally the Medical Staff Standard (MS.4.00) for ". . . maintenance of a credible process to determine competency. . . ." That is an objective, professional-medical inquiry, only superficially resembling peer-review actions reviewed and affirmed by lay judges.

[7] SilenceKills.com (see appendix_______) reports that less than 10 % of physicians speak out when they see medical errors, even life-threatening errors. *White Coat of Silence* describes nurses' reluctance to report what they see. (Appendix _______)

[8] See Charles I. Artz's paper, (appendix ____), noting how mandatory reports to a central data bank of the results of clinical privileging proceedings can ruin a good doctor.

"disruptive," because they have been effectively stripped of HCQIA fairness and due process rights.

While the stated objective of peer-review is to protect patients by improving the pool of practicing physicians (good doctors weeding out bad doctors), trending federal court decisions culminating in *Poliner* immunize illegitimate peer-review actions so it is the bad doctors who are both empowered and protected by HCQIA immunity. Because bad doctors bring in more money than good doctors,[9] hospitals are financially pressed to encourage their bad doctors to drive out their good doctors.

The principle in *Poliner* of gravest concern to Amici is the near-absolute deference to peer-reviewers regardless of their motives. Peer-reviewers and the hospital managers who control the peer-review process can professionally discredit any doctor for trumped up reasons; yet such actions are affirmed because any flimsy allegation of substandard medicine meets the *Poliner* test. Hospital managers can credibly threaten otherwise-good physicians with virtually unchallengeable peer-review actions so they act like sheep instead of watchdogs.

Consequences from *Poliner* will continue the high rate of preventable, hospital and physician-caused patient deaths and medical-error injuries. The 1999 study by the Institute of Medicine found there are nearly 100,000 medically-caused patient deaths per year.[10] Each year about 80,000 patients still die unnecessarily, deaths preventable if available knowledge and techniques had been applied.[11] Bad medicine also costs payers more including the taxpayers.[12]

---

[9] Brownlee, supra, at p.) (appendix____) for an example how good programs for patient treatment and safety often fail because cost-effective treatment, by definition, is not a big money-maker.

[10] Lucian Leape, M.D. MPH, Appendix ________.

As a percentage of the Gross National Product, current healthcare spending is about 17 % of Gross National Product and rapidly rising. Physicians, the most knowledgeable and acute onsite monitors of cost-benefit-balanced patient treatment plans oriented to economy, no longer can speak up and challenge excessive treatments and overbillings. Even when they know their hospital is committing massive MEDICARE fraud, they cannot afford to risk career and license just to save taxpayers a few hundred million dollars.[13]

Poliner impacts healthcare quality, safety and cost.

ARGUMENT

I. THE COURT SHOULD GRANT THE PETITION TO RESOLVE WHETHER THE HEALTH CARE QUALITY IMPROVEMENT ACT HAS BEEN DISPLACED BY FEDERAL COMMON LAW

The decision below conflicts with decisions of other federal courts of appeals. It is also utterly inconsistent with this Court's enduring teaching that federal common law is displaced where Congress has directly spoken to a particular subject matter.

Where, as here, "Congress addresses [a] problem formerly governed by federal common law," courts must construe the federal statute at issue with a "willingness to find congressional displacement of federal common law." *City of Milwaukee v. Illinois,* 451 U.S. 304, 317 & n.9, 315 n.8 (1981) (*"Milwaukee II"*) (emphasis omitted). This principle exists because our system of justice dictates that it is for Congress, not the federal courts, to articulate the appropriate standards to be applied as a matter of federal law." *Id.* at 317. As other courts of appeals have recognized, "once Congress has addressed a national concern, our fundamental commitment to the separation of powers precludes the courts from scrutinizing the sufficiency of the congressional solution" or "holding that the solution Congress chose is not adequate." *Illinois v. Outboard Marine Corp.,* 680 F.2d 473, 478 (7th Cir. 1982); see *Milwaukee II,* 451 U.S. at 324. See also *United States v. Oswego Barge Corp.,* (*In re Oswego Barge Corp.*), 664 F.2d 327, 335 (2d Cir. 1981) ("separation of powers concerns create a presumption in favor of [displacement] of federal common law whenever it can be said that Congress has legislated on the subject").

---

[11] HealthGrades, Appendix ________.

[12] *Overtreated*, p.___, Appendix _____.]

[13] The personal and professional consequences to Patrick Campbell, M.D., an unwelcome and unappreciated MEDICARE fraud reporter, are described in *Overtreated, p.*__, Appendix__.

Federal common law is displaced by direct congressional treatment of an issue even if Congress does not expressly state it is displacing common law. See *Resolution Trust Corp., v. Frates,* 52 F.3d 295, 297 (10th Cir. 1995) (". . . to supersede authority previously established by federal judicial ruling, Congress need not affirmatively proscribe that authority, but may do so simply by speaking directly to the issue"); *Milwaukee II,* 451 U.S. at 313-15; *Resolution Trust Corp. v. Miramon,* 22 F.3d 1357, 1360 (Fifth Cir. 1994). This Court has already made clear these principles govern federal statutory interpretation as a general rule. *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S.101, 108 (1989) (quoting *Russell,* 473 U.S. at

146). See also *Xin Liu v. Amway Corp.*, 347 F.3d 1125, 1133 n.6 (9th Cir. 2003) (interpreting Congressional intent under FMLA).

The conflict between federal common law and Congressional intent is illuminated by the Fifth Circuit's decision in the *Poliner* case, as it amplifies the diversity amongst Circuit Courts of Appeal in their interpretations of HCQIA immunity provisions intended by Congress. (42 U.S.C. § 11101-11152 (1988)). Specifically, federal appeals courts have variously interpreted section 11112(a) of HCQIA, which reflects Congress's intent "to encourage good-faith professional review activities of healthcare entities" by offering immunity protections for professional reviewers, "unless the good faith presumption is rebutted by a preponderance of the evidence."

Although lower courts have recognized that Congress intended section 11112(a) (4) of HCQIA to provide immunity for an action only if taken "in the reasonable belief that the action was warranted by the facts known," many Circuit Courts of Appeal have ignored that Congress intended certain fairness standards out of a concern that immunity under HCQIA "might be abused and serve as a shield for anti-competitive economic actions under the guise of quality controls...." H.R.Rep.No. 903, 99th Cong., 2d Sess. 9, *reprinted in* 1986 Code Cong. & Admin.News 6391. The result of this varied interpretation by Circuit Courts has been contradictory federal common law, which attempts to displace Congressional intent behind HCQIA. *See* 1986 Code Cong. & Admin. News 6392-93). A few notable decisions in the Third, Fourth, Sixth, Eighth and Eleventh Circuits are illustrative of this fact.

The Third Circuit Court in *Bhatt v. Brownsville General Hosp.,* 236 Fed. Appx. 764 (3rd Cir. 2007) has been consistent, in principle, with the dissenting opinion in *Austin v. McNamara,* 979 F.2d 728, 733 (9th Cir. 1992)[14] by acknowledging that some inquiry into the subjective belief or potential actual malice of professional reviewers must be made when determining whether a "goodfaith reasonable belief" existed in a peer-review action. *Bhatt v. Brownsville General Hosp.,* 236 Fed. Appx. 764 (3rd Cir. 2007). Likewise, the Third Circuit would grant a professional review body immunity only from civil damages and thus wrestles with the question of whether summary judgment is appropriate when an anti-trust action is alleged. *Gordon v. Lewiston Hosp.,* 423 F.3d 184 (3rd Cir. 2005). Therefore, the Third Circuit would appear to allow some factual inquiry into ill will or hostile motivations of peer reviewers.

On the other hand, the Fourth Circuit Court in *Braswell* held that "reasonableness" of a belief giving rise to the immunity provisions of HCQIA is determined by quality of investigation by the peer-review body. *Braswell v. Haywood Regional Medical Center,* 234 Fed. Appx. 47 (4th Cir. 2007). Likewise, the Fourth Circuit has held that this "reasonable belief" standard of HCQIA is satisfied if "the reviewers, with the information available to them at the time of the professional review action, would reasonably have concluded that their action would restrict incompetent behavior or would protect patients."[15] Therefore, the Fourth Circuit looks at the totality of the process plus the fundamental fairness and due process of an investigation leading up to the peer-review, as held in *Freilich v. Upper Chesapeake Health*, 313 F.3d. (2002).

---

[14] *Austin v. McNamara,* 979 F.2d 728, 733 (9th Cir. 1992) (stating that Congress intended effective peer-review to improve quality of medical care)

Similarly, the Sixth Circuit court in *Meyers v. Columbia/HCA Healthcare Corp.*, 341 F.3d 461, 468 (6th Cir. 2003), has announced that HCQIA creates an "unusual summary judgment standard." That is, "might a reasonable jury, viewing the facts in the best light for [the plaintiff], conclude that he has shown, by a preponderance of the evidence, that the defendants' actions are outside the scope of § 11112(a)?"[16] Accordingly, under *Meyers*, the plaintiff has the burden of overcoming the presumption of immunity by showing that the review process was not reasonable, but retains the right to rebut this presumption.[17] But later, Sixth Circuit joined the Third Circuit in *Talwar v. Catholic Healthcare Partners,* 258 Fed. Appx. 800 (6th Cir. 2007), which holds that the presumption of immunity may be rebutted by a showing of actual malice that is the standard for determining "objective reasonableness". *Talwar v. Catholic Healthcare Partners,* 258 Fed. Appx. 800

---

[15] *Bryan,* 33 F.3d at 1323 (citing H.R.REP. NO. 903, at 10, *reprinted in* 1986 U.S.C.C.A.N. at 6392-93). It is an objective standard, rather than a subjective good faith requirement.

Id. (citing *Austin,* 979 F.2d at 734); *Imperial v. Suburban Hosp. Ass'n, Inc.,* 37 F.3d 1026, 1030 (4th Cir. 1994). *See Vistein v. American Registry of Radiologic Technologists,* 509 F.Supp.2d

[16] *Meyers v. Columbia/HCA Healthcare Corp.,* 341 F.3d 461, 468 (6th Cir. 2003)(citing *Bryan v. James E. Holmes Reg'l Med. Ctr.,* 33 F.3d 1318, 1333 (11th Cir. 1994)(quoting *Austin v. McNamara,* 979 F.2d 728, 734 (9th Cir. 1992)).

[17] *Id.*

(6th Cir. 2007). Therefore, the Sixth Circuit would allow evidence of intentionally malicious behavior surrounding a peer-review to rebut the presumption of immunity under HCQIA. Conversely, the Eighth Circuit in *Estate of Blume,* grants professional review body immunity only from civil damages and thus contemplates whether a physician should be entitled to absolute immunity from suit resulting from a sham peer-review action. *Estate of Blume v. Marian Health Center,* 516 F.3d 705 (8th Cir. 2008). Likewise, the Eight Circuit recognizes an aggrieved physician's right to seek judicial remedies under HCQIA, which does not allow money damages, only equitable relief. *Id.* However, another Eighth Circuit Court of Appeals decision in *Lee v. Trinity Lutheran Hosp.,* 408 F.3d 1064 (8th Cir. 2005) fails to follow its prior analysis and simply holds that a reasonable and thus fair investigation by the hospital supports determination of a "reasonable belief," and thus immunity under HCQIA. *Lee v. Trinity Lutheran Hosp.,* 408 F.3d 1064 (8th Cir. 2005). Consequently, the Eighth Circuit looks only to the fairness of the overall peer-review process.

In *Bolt v. Halifax Hosp. Med. Ctr.,* 891 F.2d 810, 821 (11th Cir.) the Eleventh Circuit defines "objectively reasonable" as the instance when no "reasonable medical reviewer" would have reached the same conclusion regarding the legitimacy of a peer-review action. *Bolt v. Halifax Hosp. Med. Ctr.,* 891 F.2d 810, 821 (11th Cir.). Likewise, in *Bryan* the Eleventh Circuit observes that an extensive trial record supported reasonable belief that a peer-review action was taken in goodfaith. *Bryan v. James E. Homes Reg'l Med. Ctr.,* 33 F.3d 1318, 1326-1329 (11th Cir. 1994). The *Bolt* and *Bryan* cases illustrate how the Eleventh Circuit equates a finding that an "objectively reasonable belief" is a factual one that might be left for the jury.

The Circuit Courts of Appeal are independently deciding, on a case-by-case basis, what Congress intended under HCQIA. They all profess to uniformly impose an objective standard of "reasonableness," but differ widely in the degree to which they consider subsidiary issues of fact or the statute's requirement to afford "adequate notice and hearing procedures."[18] Lacking guidance there has emerged an inconsistent body of law, preventing a clear legal definition and understanding of this "objectively reasonable" standard. *Poliner* is a culmination of courts' confusion and trend toward interpreting Congressional intent under HCQIA as granting absolute immunity to peer reviewers. Despite evidence of malice or political and economic competition in peer-review actions, Poliner *held*, "[O]ur sister circuits have roundly rejected the argument that such subjective motivations overcome HCQIA immunity, as we do" (537 F.3d at 379-380). However, this holding by the Fifth Circuit goes much further than any prior decision in the Circuits by holding that the "objective test" means underlying motives and malice of peer reviewers are irrelevant in deciding whether peer reviewers are entitled to HCQIA immunity or not. *Id.*

As illustrated, *Poliner* is inapposite of most other Circuit Courts because, unlike its sisters, it eliminates HCQIA's requirement of fundamental fairness by peer-reviewers. The Fifth Circuit finalized a trend by the courts, which will hold that "the good or bad faith of the reviewers is irrelevant."[19] Courts are more likely to deny the possibility that there might be some point at which a belief is not "reasonable;"[20] or that will satisfy a Plaintiff's burden, which rebuts the presumption of immunity under HCQIA as Congress intended.

---

[18] *Supra*

Poliner [21] purports to uphold the due process and equal protection rights of disciplined physicians, but then boldly implies there is no set of facts that will allow a physician to rebut the "objectively reasonable" standard of HCQIA. In doing so, *Poliner* has finally announced a standard which displaces Congressional intent under HCQIA and flatly denies admissibility of any evidence relevant to rebut the presumption that the defendants possessed a "reasonable belief" the peer- review action was warranted by the facts known.[22]11

---

[19] *Poliner v. Texas Health Systems*, 537 F.3d 368, 378 (Fifth Cir. 2008).

[20] *Id.* (citing *Brader v. Allegheny Gen. Hosp.*, 167 F.3d 832, 840 (3rd Cir. 1999).

[21] *Poliner,* 537 F.3d at 378 (holding any action taken with stated purpose of protecting health care is entitled to HCQIA immunity protections). *See also Sugarbaker v. SSM Health Care,* 190 F.3d 905, 912 (8th Cir. 1999)(citing *Brader v. Allegheny Gen. Hosp.,* 167 F.3d 832, 839 (3rd Cir. 1999)(quoting *Bryan v. James E. Holmes Reg'l Med. Ctr.,* 33 F.3d 1318, 1334 (11th Cir. 1994), *cert denied,* 514 U.S. 1019, 115 S.Ct. 1363, 131 L.Ed.2d 220 (1995)).

[22] *See Sugarbaker v. SSM Health Care,* 190 F.3d 905, 912 (8th Cir. 1999)(citing *Anderson v. Liberty Lobby, Inc.,* 477 U.S. 242, 255, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986) (holding that factual dispute regarding reasonableness requires submission to jury); *Austin v. McNamara,* 979 F.2d 728, 734 (9th Cir. 1992)(holding that the standard is whether a reasonable jury would find Defendant's actions outside scope of § 11112(a)).

No allegation of incompetence in a peer-review action needs to be true; a mere allegation against a physician in a peer-review action will be sufficient to call a doctor incompetent and destroy his medical practice. However, beware, because if mere allegation is sufficient, then no physician will be judged competent because *Poliner* allows peer-reviewers to cherry pick "facts" to support badfaith, sham peer-review actions against any physician.[23]

Poliner displaces Congressional intent under HCQIA and seeks to replace it with federal common law, denying fundamental rights of "physicians [to] receive fair and unbiased review [and] to protect their reputation and medical practices." 1986 Code Cong. & Admin.News at 6393. This extreme *Poliner Rule* must be wound back to where the § 11112(a)(4) "reasonable belief" on the part of the peer-reviewers required to enjoy § 11111(a)(1) immunity is based on all facts in the record, as Congress intended.

The *Poliner* Court goes on to inconsistently hold it is an objective inquiry that considers the totality of the circumstances, citing *Imperial v. Suburban Hosp. Ass'n, Inc.*, 37 F.3d 1026, 1030 (4th Cir. 1994). It also did not matter to the Fifth Circuit that the patient care demanded by the peer-reviewers may not actually be beneficial, in fact harmful, to a patient.

---

[23] *Poliner v. Texas Health Systems,* 537 F.3d 368 (Fifth Cir. 2008)(stating "[I]t bears emphasizing that 'the good or bad faith of the reviewers is irrelevant' (citing *Brader v. Allegheny Gen. Hosp.* 167 F.3d 832, 840 (3rd Cir. 1999)). Nevertheless, the *Poliner* Court goes on to inconsistently hold that it is an objective inquiry in which we consider the totality of the circumstances citing *Imperial,* 37 F.3d at 1030. It also did not matter to the Fifth Circuit that the care demanded by the reviewers may not actually be beneficial, or in fact harmful, to a patient.

II. MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT OF 2008, REQUIRES A SHIFT IN INTERPRETING HCQIA'S FAIRNESS AND DUE PROCESS STANDARDS FOR PEER-REVIEWED PHYSICIANS. AFTER JULY 2008, HCQIA MUST BE INTERPRETED ACCORDING TO JCAHO STANDARDS ISSUED AND ENFORCED PURSUANT TO EXPRESS STATUTORY DELEGATION TO JCAHO FROM THE SECRETARY OF HEALTH AND HUMAN SERVICES.

Procedural aspects of *Poliner* are like *Kennedy v. Louisiana* (decided June 25, 2008, rehearing considered, but modified October 1, 2008). *Kennedy* held the death penalty could not be imposed for rape of a child, not knowing Congress had amended the Uniform Code of Military Justice in 2006 to provide the death penalty for military personnel convicted of child rape.

Similarly, *Poliner* was decided by the Fifth Circuit July 23, 2008, with no awareness by the parties or the Court that Congress passed a law eight days before, on July 15, 2008, fundamentally changing HCQIA's fairness and due process requirements for peer-reviewed physicians. No one realized the effect of the Congressional action until after the time for reconsideration expired on August 6, 2008.

III. HCQIA'S DUE PROCESS, EVIDENTIARY, AND RELATED FAIRNESS REQUIREMENTS

HCQIA profoundly affects how hospitals conduct peer-review proceedings, setting minimum fairness and due process standards that peer-reviewers and peer-review actions must meet to qualify for immunity. What is "fair" to the physician (§ 11112 (a)(3)) or appropriate due process depends on the baseline assumptions pervading these statutory guarantees, in the factual circumstances under review. Until Congress spoke, courts looked to HCQIA, plus judicial interpretations of the fairness and other notice and due process protections Congress expressly provided physicians who are peer-reviewed.

Unfortunately, courts interpreted HCQIA fairness and due process without understanding that the Act's general fairness and due process requirements have been implemented by a comprehensive set of regulations. These regulations implementing HCQIA's fairness and due process guarantees have been issued in the form of standards for accrediting hospitals that elected to be regularly surveyed and accredited by JCAHO.

By statute (42 U.S.C. § 1395bb) hospitals have the option to be inspected by MEDICARE regulators to be certified as eligible to receive MEDICARE payments, or be accredited by JCAHO.

Instead of federal HHS inspectors periodically investigating whether MEDICARE payment standards are met, nearly all hospitals have elected to be regularly surveyed and accredited by JCAHO. The practical and legal advantage for a hospital is that JCAHO holds delegated governmental power to issue an automatic, immediate and final certification of MEDICARE-compliance. Hospitals can receive MEDICARE payments without submitting to inspection by federal MEDICARE inspectors.

Because of a statute passed in 1965 (42 USC § 1395bb, below) JCAHO accreditation is final. Accreditation is binding on HHS and MEDICARE managers because JCAHO certification "deems" a hospital MEDICARE-compliant. Once JCAHO accredited a hospital, §1395bb did not allow MEDICARE to inspect that hospital to determine if it met MEDICARE rules, called "Conditions of Participation" (CoP). It was not until summer 2008 that HHS regained its deeming authority Congress delegated exclusively to JCAHO in 1965.

Although in legal reality the clinical privileging of physicians was governed by JCAHO accreditation standards used to deem hospitals eligible for MEDICARE dollars, neither healthcare attorneys nor the courts understood that JCAHO holds and exercises government powers. JCAHO has federal functions similar to other quasi-government delegatees like the New York Stock Exchange and the National Association of Securities Dealers (now the Financial Industry Regulatory Authority, FINRA) that regulate securities' transactions for the federal government.

It was not until after Congress passed the Medicare Improvements for Patients and Providers Act (HR 6331), that healthcare attorneys began to understand that JCAHO hospital accreditation standards and yearly updates govern patient care including granting or modifying physicians' clinical privileges.

By a reverse legislative act, revoking the existing delegation to JCAHO of HHS's powers, Congress declared that JCAHO has held and exercised governmental authority. A power must exist to be revoked; and the title of § 125 of HR 6331, was: "REVOCATION OF UNIQUE DEEMING AUTHORITY OF JCAHO."

Since § 125 of H.R. 6331 was passed, we now know that since 1965 JCAHO standards have been, are, and will be until 2010, far more than guidelines for hospitals' management of their medical staffs, for terms and due process requirements in medical staff bylaws, and the care and safety of patients. By revoking in very express language the delegation of "unique deeming authority," Congress finally made clear that JCAHO is, until 2010, HHS's agent for deeming MEDICARE eligibility.

The consequence of this recognition is that JCAHO issuances and updates in the form of accreditation standards have served as federal (and state, see below) patient care and physician clinical privileging regulations.

These regulations, issued in the form of "accreditation standards," govern all JCAHO-accredited-Medicare-eligible hospitals. JCAHO's *Comprehensive Accreditation Manual for Hospitals* (CAMH) and its frequent updates are the law for JCAHO-accredited hospitals as to patient care and safety and related activities like managing their medical staffs, clinical privileging, and peer-review.

When Medicare began in 1965, the Department of Health, Education and Welfare (HEW, now Health and Human Services [HHS]), lacked in-house expertise to establish and update standards for hospitals' eligibility for MEDICARE payments.

HEW looked to JCAH, a nonprofit formed in 1951 by medical and hospital associations then operating a national accreditation program. JCAH already had the expertise and structure to promulgate, update and enforce hospital standards. By 1965, JCAH surveyed and accredited about 60 % of U.S. hospitals.

So that MEDICARE funds were not paid to substandard hospitals, Congress delegated to JCAH—almost entirely in many respects—the (HEW) Secretary's statutory authority to determine which hospitals met MEDICARE requirements. "JCAHO standards, in fact, became the original CoP"[24]. As passed in 1965, §1395bb of 42 U.S.C. provided (with exceptions not relevant here):

> . . . [I]f . . . an institution is accredited as a hospital by [JCAHO], and
>
> . . . [the Secretary or a State agency the Secretary may designate is provided] . . a copy of the most current accreditation survey of such institution . . . then, **such institution shall be deemed to meet [MEDICARE Conditions of Participation, as provided in 42 U.S.C. § 1395x et al.].** (Emphasis added).

CAMH standards for medical staff bylaws and physician credentialing have not been advisory standards as most healthcare attorneys and courts assumed. Despite the failure of attorneys and courts to comprehend until Congress so declared, JCAHO has had governmental powers.

Congress did not pass new language and try to make it retroactive. It simply re-interpreted §1395bb by clearly stating JCAHO has had "Unique Deeming Authority." After § 125 is in effect, JCAHO and its accreditation decisions based upon its published regulatory standards

> ". . . may [be] . . . recognize[d] . . . upon such terms and conditions, and upon submission of such information, as the Secretary may require" (H.R. 6331, § 125 (c)).

Texas also accepts accreditation in lieu of State inspection and certification (Health and Safety Code,

---

[24] Lisa Sprague, Hospital Oversight in Medicare: Accreditation and Deeming Authority, National Health Policy Forum, NHPF Issue Brief No. 802/May 6, 2005, p. 4.

§ 222.024), making JCAHO standards Texas hospital law for JCAHO-accredited hospitals. When they submit to the jurisdiction of JCAHO, hospitals bind themselves to follow relevant JCAHO policies as a matter of federal and Texas law.

Judicial recognition that JCAHO standards govern hospitals, starting with correcting the underlying legal mistake in *Poliner*, will reverse the trend of peer-review cases decided under HCQIA. Badfaith or economically motivated peer review, and flimsy findings of substandard care by the targeted peer-reviewed physicians, no longer can support judgments based on the presumed "objective reasonableness" of peer-review actions. From now on HCQIA's fairness and due process requirements for peer-review procedures and peer-review actions must be read in the context of JCAHO credentialing standards viewed as controlling law. CAMH requires all decisions on physicians' privileges to be uniform, fair, and directly related to patient care.[25]

This gross legal error can be corrected judicially. HCQIA is well-written and well-intended, but 20 years of misinterpretations reversed the intended effects, starting with the majority's opinion in *Austin v. McNamara*, above. Judge Pregerson, the dissenter in *Austin*, got it right:

> Section 11112 (a) reflects Congress's intent 'to encourage goodfaith professional review activities of healthcare entities'" (979 F.2d at 741).

---

[25] CAMH 2000, MS.5.4.4, e.g., provides that "Decisions on reappointments or on revocation, revision, or renewal of clinical privileges must consider criteria that are directly related to the quality of care."

Once courts acknowledge that JCAHO standards pervade and inform HCQIA, SSI will have no quarrel with HCQIA's language, presumptions of immunity, or due process limitations. HCQIA was not intended to immunize badfaith, malicious or economically motivated peer-review. HCQIA should be interpreted so that JCAHO physician appointment, reappointment, clinical privileging, and peer-review action requirements inform all relevant parts of HCQIA.

Now that Congress declared when it passed HR 6331, that JCAHO standards govern all hospital actions pertaining to physicians, it appears entirely appropriate for this Court to correct this error that results in so many patients dying unnecessarily and healthcare costs rising. Good public policy can be made simply by interpreting a statute as Congress intended.

There is no need to amend. SSI believes HCQIA was intended to be read parallel with JCAHO standards. When the bill was debated in the mid-1980s, JCAHO standards were the prevailing hospital and physicians' standards and protections, and it was well known that JCAHO accreditation and credentialing standards and policies were updated every year. Nothing in HCQIA says it was to be frozen in time and interpreted separately from the continually evolving JCAHO standards.

It is unfortunate Congress acted too late to have these legal realities presented and argued before the Fifth Circuit. Neither counsel nor the deciding court was aware of Congress' then-recent actions.

Amicus SSI respectfully prays that this Court grants Certiorari and interprets HCQIA so physicians can trust they have enforceable due process rights to sustain the independence and free speech protections they need to advocate for patients and make healthcare better, safer, and cheaper.

Respectfully submitted,

PAUL S. BLUMENTHAL *
JEFFREY GRASS
Of Counsel
LAW OFFICE OF PAUL S.
BLUMENTHAL, P.A.
Suite 301, West Court Building
2448 Holly Avenue
Annapolis, MD 21401
(410) 266-2430

* Counsel of Record

November 24, 2008

APPENDIX

APPENDIX A

The "White Coat" of Silence

LET'S CONSIDER A SCENARIO, that may or may not be hypothetical—that will be for you to decide. In an unnamed hospital, a newly appointed Chief Nursing Officer (CNO) is hired as a change agent, or at least that is what she is told by the hospital's Chief Executive Officer (CEO) and several Vice Presidents. As a first order of business, the CNO begins to document problem areas at the hospital. The list includes a director of Nursing (DON) WHO prevaricates, especially when it comes to defining staffing needs; abandonment of duty by some nurses in the chain of command; a nurse who continues to make medication administration errors; the failure of the computerized charting system to perform as expected; and other problems of the same importance.

When verbal reports to a superior fall on deaf ears and generate responses such as "the DON is doing what she can," the CNO decides to write a detailed memo outlining the problems and her recommendations. A copy of the CNO's report the is given to the CEO and all department VP'S including the CNO's direct superior. One would expect that hospital administration would show appropriate concern for the severity of the documented deficiencies and pain for immediate corrective action. However, this is a management-impaired hospital and following the unspoken rule of the hospital following the unspoken rule of "killing the messenger," the CNO is sacrificed for failing to adhere to another unspoken rule of the hospital

By Geneviève M. Clavreul, RN, PhD.

Hospitals, like police departments and other institutions, have their own codes of silence to protect against human error—no malice, no ill intent, no nefarious plan—just plain old human error.

and nursing administration, which is "bring us no bad news."

For many, the above example will have the ring of truth, because this situation exists in their hospital today, or in the past. There will be others who say their hospital would never tolerate such a practice. But the above does put a spotlight on what I have come to call the "White Coat of Silence."

Hospitals, like police departments and other institutions, have their own codes of silence. This code was established to give a person some protection from the consequences of what is often just human error—no malice, no ill intent, no nefarious plan—just plain old human error. However, as in police work, there are times when the white coat of silence is extended to cover the mistakes of a person who is incompetent or unethical. When this happens, the healthcare community violates its trust with the public it serves and bad outcomes follow.

The cloak of privacy offered by quality improvement projects should not be confused with the white coat of silence. The shield of privacy is invoked to allow the hospital staff to freely and fully investigate a medical or nursing mishap or error. This shield is offered under the theory that privacy assurance will allow the nurse or doctor, without fear of retribution and accusation, to discuss the mistake that occurred. This does not mean that the nurse or doctor responsible is free from consequence if an event is deemed caused by negligence or poor care.

An effective quality improvement process leads to an environment where patient rights and care are placed at the forefront without relegating the nursing and medical staff to second-class status. The white coat, on the hand, places emphasis on protecting the nursing and medical staff first and encourages an environment where patient rights and care are not the core focus of the healthcare team.

The white coat flourishes in an environment where hospital administration and nursing management in particular, is viewed as hostile towards good nursing practice. This insidious code creeps into a hospital as a defense against what is viewed by employees as an administration that is unresponsive and often retaliatory.

Through society may reward the whistle blower for calling attention to malfeasance, safety issues, and, in the case of nursing, poor or negligent patient care––the reality is that the administration, and in some cases the nursing team itself, does not support the nurse who is a whistle blower. It is an unfortunate occurrence within nursing, and it doesn't have to be this way.

I was having lunch with a nurse whom I had known and worked with many years ago. Catching up on old times we chatted about the numerous experiences and frustrations our many years of nursing had brought us. She shared with me an experience she had one night many years ago at one of Los Angeles finest hospitals.

She and five other nurses, a tech, and two doctors were preparing to move a patient into surgery. The need for surgery was immediate and urgent, and as they prepared the patient one of the doctors handed her a pre-filled syringe and ordered that she administer it to the patient. Since she did not draw the medication and, therefore, did not know what was in the syringe she asked the doctor what the syringe contained. He refused to tell her, stating instead that without it the patient would suffer ill effects and that she had t administer it.

Of course she refused, and stated that the physician should administer it instead. He refused and then ordered one of the other nurses to do it. After much haranguing and brow beating one of the other nurses acquiesced and administered the injection of the mystery drug. Afterwards, she reported the occurrence to nursing service; each of the other five nurses confirmed her story and supported her complaint. But the tech and the mystery syringe doctor both developed amnesia. Shortly after the complaint, the six nurses began to find themselves pressured t find other employment–the white coat of silence strikes again.

A reasonable person might have thought that the doctor who insisted that the nurse administer an unidentified drug would have been the one to be made to suffer for his unprofessional and possibly dangerous actions, but of course, hospital management is not always known for reasonable behavior.

What happened to my friend and the other nurses is the byproduct of poor and weak management, not an uncommon occurrence in the hospital setting.

All too often a nurse who makes a complaint about another nurse or doctor is made to weigh in advance the possible repercussions to herself. Often the act of reporting their suspicions to the charge nurse or head nurse is enough to mark the nurse as a troublemaker and thus, a potential victim of kill the messenger syndrome. Poor managers often feel threatened by the nurse who steps forward, especially if the nurse being reported is perceived by nursing management as a hard worker.

The weak manager often confuses the nurse who is willing to work any and all shifts, multiple days, fetch coffee, run errands, with being a nurse, when in reality this nurse is usually a sycophant who is undermining the esprit de corps. A consequence of the sycophant's behavior is that the manager often rewards them for being a teacher's pet while the very real concern of the whistle blower is ignored and the whistle blower is the one who is punished. It only takes one or two negative consequences before the nursing staff gets the message. Good nurses start updating their resume or, worse, stop caring.

Does the white coat have no rule nursing practice in our hospitals? Of course not! Most nurses abhor the thought of poor nursing care being hidden, yet feel totally helpless to do anything about it for fear of losing their job or, worse yet, their license.

The white coat thrives in two environments: where there is poor or weak nursing management that does not advocate for patients and nurses, and where nurses fail to support the whistle blower.

Reporting suspicions to the charge nurse is often enough to get marked as a troublemaker and potential victim of the kill the messenger syndrome.

Changing this work environment is not impossible. When nurses work together to define and enforce the highest standards of nursing practice then nursing management has little choice but to respond. They learn that nurses demand leaders to show backbone. Mediocre nurses quickly change their behavior or move on when they realize that their obsequious and sycophantic behavior is unrewarded. Floor nurses can have a dramatic effect on who the hospital administration appoints as the CNO, and ultimately on who the CNO appoints as DON, who the DON appoints a s Head Nurse, and so on.

THE WHITE COAT OF SILENCE IS NURSING'S DIRTY LITTLE SECRET. It can only thrive in an environment that is permissive and unresponsive. If you know that you are working in a hospital where the "white coat of silence" is the rule and not the exception, there are some steps you can take to protect your patients and yourself.

FIRST AND FOREMOST, always document. Although documenting can be time consuming, it is important to create a paper trail.

SECOND, become thoroughly familiar with your hospital's quality improvement protocol and employee discipline process.

THIRD, when reporting unsafe nursing practices, sentential events, possible errors, and so on, always follow the chain of command and keep a copy of the documentation that you submitted.

FOURTH, if the situation worsens, or you begin getting the feeling that you are working around with a "target on your back," give serious consideration to looking for a position in another hospital.

It may seem extreme to change jobs when confronted with the white coat but it's not. If you are working in a hospital where the norm is to ignore real and valid concerns about safe nursing practice and good patient care you cannot personally solve a system-wide problem. What you can do, however, is to provide the documentation that administration was informed, but that they chose to remain ignorant of the problems. Why? Because when the hospital suffers an event big enough—if it tolerates a white code of silence, it eventually will—then it won't be able to hide its practices.

Then your documentation can be used to instigate change.

Genevieve M. Clavreul is a health care manage-ment consultant. She is an RN and has experience as a director of nursing and as a teacher of nursing management. She can be reached at: Solutions Outside the Box; PO Box 867, Pasadena, CA; gmc@solutionsoutsidethebox.net; 626-844-7812.

THIS ARTICLE IS ARCHIEVED ON LINE.

http://www.solutionsoutsidethebox.net/documents/2005/White%20Coat%20of%20Silence.pdf

The 'White Coat' of Silence: Working Nurse Feb 21, 2005 pages: 11-15.

APPENDIX B

FOR IMMEDIATE RELEASE	CONTACT:
January 26, 2005	Mary Dondiego
	(801) 724-6323

New Study Finds U.S. Hospitals Must Improve Workplace Communication to Reduce Medical Errors, Enhance Quality of Care

Expert Panel Issues Call-to-Action with New National Standards and Training Recommendations

WASHINGTON—January 26, 2005—According to findings from a study released today in a national briefing of healthcare stakeholders, the prevalent culture of poor communication and collaboration among health professionals relates significantly to continued medical errors and staff turnover. Additionally, a lack of adequate support systems, skills and personal accountability results in communication gaps that can cause harm to patients.

A national study of more than 1,700 nurses, physicians, clinical-care staff and administrators found that fewer than 10 percent address behavior by colleagues that routinely includes trouble following directions, poor clinical judgment or taking dangerous shortcuts. In all, the study pinpoints seven categories of problems that are frequently encountered, yet rarely addressed. The study was co-sponsored by the American Association of Critical-Care Nurses (AACN) and VitalSmarts, a company specializing in leadership training and organizational performance.

"This research validates what our 100,000 constituents have communicated to us as the number one barrier hindering optimal care for patients," said

Kathy McCauley, RN, PhD, BC, FAAN, FAHA, president, AACN. "Too often, improving workplace communication is seen as a 'soft' issue—the truth is we must build environments that support and demand greater candor among staff if we are to make a demonstrable impact on patient safety."

To drive the cultural transformation needed to improve communication in hospitals, AACN unveiled today a set of national standards to promote skilled communication and collaboration among nurses and other caregivers. The AACN standards and VitalSmarts recommendations emphasize the urgent need for hospitals to implement initiatives, especially communication training and education, to ensure that healthcare professionals deliver safe, high quality care to their patients.

AACN and VitalSmarts combined their resources to better understand communication problems in hospitals through the survey *Silence Kills: The Seven Crucial Conversations for Healthcare*. Among the study's key findings:

> 84 percent of physicians and 62 percent of nurses and other clinical-care providers have seen coworkers taking shortcuts that could be dangerous to patients.
>
> 88 percent of physicians and 48 percent of nurses and other providers work with people who show poor clinical judgment.
>
> Fewer than 10 percent of physicians, nurses and other clinical staff directly confront their colleagues about their concerns, and one in five physicians said they have seen harm come to patients as a result.

> The 10 percent of healthcare workers who raise these crucial concerns observe better patient outcomes, work harder, are more satisfied and are more committed to staying in their jobs.

"People frequently see these problems, but too often they fail to talk about them," says Joseph Grenny, president of VitalSmarts and co-author of VitalSmarts' *New York Times* best-selling books *Crucial Conversations and Crucial Confrontations*. "Healthcare professionals who embrace the findings of this study and start talking candidly and safely about these seven problems will find that outcomes can improve dramatically."

According to panelist Dennis S. O'Leary, MD, president of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), communication is a top contributor to medical errors in healthcare facilities. "The standards and recommendations put forth today make an important contribution to beginning to solve the identified communication problems," said Dr. O'Leary.

Panelist Karlene Kerfoot, RN, PhD, CNAA, FAAN, senior vice president for patient care services and chief nurse executive at Clarian Health Partners in Indianapolis, explained that by focusing on workplace communication improvements, Clarian has experienced greater recruitment and retention success and improved safety overall.

"Nurses must be as proficient at handling personal communication as they are in clinical skills," said Connie Barden, RN, MSN, CCNS, CCRN, executive editor of *AACN's Standards for Establishing and Sustaining Healthy Work Environments: A Journey* to

Excellence. "According to the Standards, a culture of safety and excellence requires that individual nurses and healthcare organizations make it a priority to develop communication skills that are on par with expert clinical skills."

# # #

For copies of the Silence Kills study report and the *AACN Standards for Establishing and Sustaining Healthy Work Environments*, visit http://www.rxforbettercare.org.

With 100,000 members and constituents, the American Association of Critical-Care Nurses is the largest specialty nursing organization in the world. Its headquarters are located in Aliso Viejo, Calif. Founded in 1969, the association has more than 240 chapters in the U.S. and abroad and is working toward a healthcare system driven by the needs of patients and their families, where critical care nurses make their optimal contribution. Complete information about AACN is available at http: / / www.aacn.org.

A world leader in leadership training and organi zational performance, VitalSmarts. (http://www.vitalsmarts.com) *provides products and services to hundreds of companies, including over 300 of the Fortune 500. For over twenty-five years, and with over 20,000 participants, the company principals have researched methods for bringing about systematic and lasting change.*

APPENDIX C

Contact: Scott Shapiro
(720) 963-6584
sshapiro(a,healthgrades.com

[Logo]

Todd VanFossen
(608) 695-3992
tvanfossen@healthgrades.com

DEATH RATE 70% LOWER AT NATION'S TOP-RATED HOSPITALS: HEALTHGRADES 11th ANNUAL HOSPITAL QUALITY STUDY

—The Most Comprehensive Annual Study of Hospital Quality in America Examines 41 Million Patient Records at 5, 000 Hospitals Over Three Years; Mortality Rates Improve Nationally—

—City and State-Level Hospital Death Rates Released—

—Hospital Quality Ratings Available Free to Consumers at HealthGrades.com—

GOLDEN, Colo. (October 14, 2008)—Patients have on average a 70 percent lower chance of dying at the nation's top-rated hospitals compared with the lowest-rated hospitals across 17 procedures and conditions analyzed in the eleventh annual *Health Grades Hospital Quality in America Study*, issued today by HealthGrades, the leading independent healthcare ratings organization.

While overall death rates declined from 2005 to 2007, the nation's best-performing hospitals were able to reduce their death rates at a much faster rate than poorly performing hospitals, resulting in large state, regional and hospital-to-hospital variations in the quality of patient care, the study found.

HealthGrades Hospital Quality in America Study, also found that if all hospitals performed at the level of five-star rated hospitals, 237,420 Medicare dealths could potentially have been prevented over the three years studied. More than half of those deaths were associated with four conditions: sepsis (a life-threatening illness caused by systemic response to infection), pneumonia, heart failure and respiratory failure.

The HealthGrades study of patient outcomes at the nation's approximately 5,000 hospitals is the most comprehensive annual study of its kind, analyzing more than 41 million Medicare hospitalization records from 2005 to 2007. The study examines procedures and conditions ranging from heart valve-replacement surgery to heart attack to pneumonia.

Based on the study, HealthGrades today made available its 2009 quality ratings for all nonfederal hospitals in the country at www.healthgrades.com, a Web site designed to help individuals research and compare local healthcare providers.

Full reports on death rate trends in each of the 50 states and the District of Columbia are available in the study. And, for the first time, HealthGrades has released hospital death rates for the nation's 15 largest metropolitan statistical areas: New York, Los Angeles, Chicago, Dallas, Philadelphia, Houston, Miami, Washington D.C., Atlanta, Boston, Detroit, San Francisco, Phoenix, Riverside-Inland Empire (CA) and Seattle. Large variation exists between major metropolitan areas.

"Geography should not be a major factor in patients' outcomes. If our nation's hospitals are to close the quality gap and guarantee an equally high level of medical care for every patient, no matter where he or she lives, it will require a commitment by our nation and its communities to demand more from quality improvement," said Samantha Collier, MD, Health-Grades' chief medical officer and a study author. "Until then, it is imperative that anyone seeking medical care at a hospital do their homework and know the hospital's quality ratings before they check in."

The study's major findings are:

> The nation's inhospital risk-adjusted mortality rate improved, on average, 14.17 percent from 2005 to 2007, but the degree of improvement varied widely by procedure and diagnosis studied (range: 6.30% to 20.94%). Five star-rated hospitals' mortality rates continue to improve at a faster rate (13.18%) than 1- or 3-star hospitals (12.30% and 13.14%, respectively).
>
> Large gaps persist between the "best" and the "worst" hospitals across all procedures and diagnoses studied. Five star-rated hospitals had significantly lower risk-adjusted mortality across all three years studied. Across all procedures and diagnoses studied, there was an approximate 70 percent lower chance of dying in a 5-star rated hospital compared to a 1-star rated hospital. Across all procedures and diagnoses studied, there was an approximate 50 percent lower chance of dying in a 5-star rated hospital compared to the U.S. hospital average.
>
> If all hospitals performed at the level of a 5-star rated hospital across the 17 procedures and diagnoses studied, 237,420 Medicare lives

> could have potentially been saved from 2005 to 2007.
>
> Fifty-four percent (128,749) of the potentially preventable deaths were associated with just four diagnoses: Sepsis, heart failure, pneumonia and respiratory failure.
>
> Variation in risk-adjusted mortality exists not only at the national level but also at the state and regional levels. The greatest quality differences between states occurred in hospital death rates for heart failure, pulmonary, stroke and cardiac surgery.
>
> The region with the lowest overall risk-adjusted mortality rates was the East North Central region (IL, IN, MI, OH, and WI), while the East South Central region (AL, KY, MS, and TN) had the highest mortality rates.
>
> The East North Central region (IL, IN, MI, OH, and WI), had the highest percentage of best-performing hospitals at 26 percent. Less than seven percent of hospitals within the New England region (CT, MA, ME, NH, RI, and VT) were top-performing hospitals.

In the study's analysis of hospital death rates, the following 17 procedures and conditions were analyzed: bowel obstruction, chronic obstructive pulmonary disease, coronary bypass surgery, coronary interventional procedures (angioplasty/stent), diabetic acidosis and coma, gastrointestinal bleed, gastrointestinal surgeries and procedures, heart attack, heart failure, pancreatitis, pneumonia, pulmonary embolism, resection/replacement of the abdominal aorta, respiratory failure, sepsis, stroke, and valve replacement surgery. The full study, along with its methodology and state-by-state hospital-quality statistics, can be found at www.healthgrades.com.

HealthGrades' Star Ratings of Hospitals

On its Web site, HealthGrades offers, free to consumers, quality ratings of 27 procedures and treatments for every nonfederal hospital in the country. The Web site is designed so that consumers can easily compare patient outcomes at their local hospitals for procedures ranging from aortic aneurysm repair to bypass surgery. Each hospital receives a star rating based on its patient outcomes in terms of mortality or complication rates for each procedure or treatment. Hospitals with outcomes that are above average to a statistically significant degree receive a five-star rating. Hospitals with average outcomes receive a three-star rating, and hospitals with outcomes that are below average receive a one-star rating. Because no two hospitals or their patients' risk profiles are alike, HealthGrades employs extensive risk-adjustment algorithms to ensure that it is making fair *comparisons.*

About Health Grades

Health Grades, Inc. (Nasdaq: HGRD) is the leading healthcare ratings organization, providing ratings and profiles of hospitals, nursing homes and physicians. Millions of consumers and many of the nation's largest employers, health plans and hospitals rely on HealthGrades' independent ratings, advisory services and decision-support resources to make healthcare decisions based on the quality and cost of care. More information on the company can be found at www.healthgrades.com.

APPENDIX D

In the Literature

FIVE YEARS AFTER TO *ERR IS HUMAN*: WHAT HAVE WE LEARNED?

Five years ago, the Institute of Medicine (IOM) issued its landmark report on medical errors, *To Err Is Human: Building a Safer Health System*. The report's finding that as many as 98,000 people die each year due to medical errors ignited professional and public dialogue. Patient safety has since become a frequent topic for journalists, health care leaders, and consumers, but is health care any safer now? And if not, why not?

Two authors of the IOM report, Lucian Leape, M.D., of the Harvard School of Public Health, and Donald Berwick, M.D., of the Institute for Healthcare Improvement, endeavor to answer these questions in "Five Years After To Err Is Human: What Have We Learned?" (*Journal of the American Medical Association*, May 18, 2005). Despite finding small improvements at the margins—fewer patients dying from accidental injection of potassium chloride, reduced infections in hospitals due to tightened infection control procedures—it is harder to see the overall, national impact, Leape and Berwick say. "[T]he groundwork for improving safety has been laid in these past five years but progress is frustratingly slow," they write.

Accomplishments

While *To Err Is Human* has not yet succeeded in creating comprehensive, nationwide improvements, it has made a profound impact on attitudes and organizations. First, it has changed the way health care professionals think and talk about medical errors and injury, with few left doubting that preventable medical injuries are a serious problem. "It truly changed the conversation," say Leape and Berwick. A central concept of the report—that bad systems and not bad people lead to most errors—has since become a mantra in health care.

The second major effect of the report was that it helped recruit a broad array of stakeholders to advance the cause of patient safety. In 2001, Congress responded to the IOM recommendations by allocating $50 million annually for patient safety research to the Agency for Healthcare Research and Quality (AHRQ), the lead federal agency for health care safety. Other important players that have emerged include the Veteran's Health Administration, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the Centers for Medicare and Medicaid Services (CMS), as well as purchasers and payers. However, the most important stakeholders, say the authors, are the physicians, nurses, therapists, and pharmacists who have become much more alert to safety hazards and who are committed to making improvements on the front lines.

Clearly, the report has also produced real changes in the practice of health care. In 2003, JCAHO began requiring hospitals to implement 11 safety practices, including improving patient identification, communication, and "surgical site verification" (marking a body part to ensure surgery is performed on the correct part). More safe practices will be added in 2005. In addition, teaching hospitals initiated new residency training hour limitations in 2003, aimed at reducing errors due to fatigue.

Challenges

With all this growing awareness and activity, why is health care not measurably safer? The answers, the authors say, lie in the very culture of medicine. Creating a culture of safety requires changes that physicians may perceive as threats to their autonomy and authority. Fear of malpractice liability, moreover, may create an unwillingness to discuss or even admit to errors. Other issues include the complexity of the health care industry, with its vast array of specialties, subspecialties, and allied health professionals; a lack of leadership at the hospital and health plan level; and a scarcity of measures with which to gauge progress.

The current reimbursement system can also work against safety improvement and, in some cases, may actually reward less-safe care, the authors say. For instance, some insurance companies will not pay for new practices to reduce errors, while physicians and hospitals can bill for additional services that are needed when patients are injured by mistakes.

Next Steps

Despite formidable barriers, the authors expect to see dramatic advances in the next five years in the following areas: implementation of electronic health records, wide diffusion of proven and safe practices, spread of training on teamwork and safety, and full disclosure to patients following injury. However, while these advances will have an impact on reducing errors, they represent only a small fraction of the work that needs to be done. To create comprehensive, nationwide change, pressure must be applied to the health care industry. Public outrage, reformed reimbursement policies, and regulation can create some of this needed pressure. In addition, the authors suggest payment incentives to accelerate widespread adoption. It may be equally important, they say, to create negative financial consequences for hospitals or organizations that continue to perform unsafe practices.

The single most important step, however, is to set and adhere to "strict, ambitious, quantitative, and well-tracked national goals," say Leape and Berwick. They urge AHRQ to bring together organizations, including JCAHO, CMS, and the American Medical Association, to agree to a set of patient safety goals to be reached by 2010. The most important lesson of the past five years, the authors argue, is that "we will not become safe until we choose to become safe."

Clinical Effectiveness of Safe Practices

Intervention	Results
Physician computer order entry	81 % reduction of medication errors[a,b]
Pharmacist rounding with team	66% reduction of preventable adverse drug events[c]
	78% reduction of preventable adverse drug events[d]
Rapid response teams	Cardiac arrests decreased by 15%[e]
Team training in labor and delivery	50% reduction in adverse outcomes in preterm deliveries[f]
Reconciling medication practices upon hospital discharge	90% reduction in medication errors[g]

---

[a] D. W. Bates, J. M. Teich, J. Lee et al., "The Impact of Computerized Physician Order Entry on Medication Error Prevention," Journal of the American Medical Informatics Association 6 (July/August 1999): 313-21.

[b] D. W. Bates and A. A. Gawande, "Improving Safety with Information Technology," New England Journal of Medicine 348 (June 19, 2003): 2526-34.

[c] L. L. Leape, D. J. Cullen, M. D. Clapp et al, "Pharmacist Participation on Physician Rounds and Adverse Drug Events in the Intensive Care Unit," Journal of the American Medical Association 282 (July 21, 1999): 267-70.

[d] S. N. Kucukarslan, M. Peters, M. Mlynarek, D. A. Nafziger, "Pharmacists on Rounding Teams Reduce Preventable Adverse Drug Events in Hospital General Medicine Units," Archives of Internal Medicine 163 (September 22, 2003): 2014-18.

[e] L. Landro, "The Informed Patient: Hospitals Form 'SWAT' Teams to Avert Deaths," Wall Street Journal, December 1, 2004.

[f] B. Sachs, Beth Israel Deaconess Medical Center, written communication, October 2004.

[g] J. D. Rozich and R. K. Resar, "Medication Safety: One Organization's Approach to the Challenge," Journal of Clinical Outcomes Management 8 (October 2001): 27-34.

Ventilator bundle protocol	Ventilator-associated pneumonias decreased[h]

---

[h] J. Whittington, written communication, March 2005.

Source: L. L. Leape and D. M. Berwick, "Five Years After To Err Is Human: What Have We Learned?" Journal of the American Medical Association 293 (May 18, 2005): 2384-90.

APPENDIX E

Joint Commission Forms National Task Force To Review Relevance of Standards, Compliance Requirements

Media Contact:
Charlene Hill
Media Relations Manager
630.792.5175
E-mail: chill@jcaho.org

(Oakbrook Terrace, Ill.—April 30, 2001) The Joint Commission on Accreditation of Healthcare Organizations today launched a sweeping review of its hospital standards and requirements for demonstrating compliance with standards.

An 18-member task force will pinpoint which accreditation standards are most relevant to the safety and quality of patient care, and target for elimination or modification those standards that do not contribute to good patient outcomes. In addition, the task force will identify redundant and overly burdensome documentation requirements for potential streamlining, and identify areas needing additional focus.

The project is part of a concerted effort by the Joint Commission to enhance the value and effectiveness of its accreditation process. The initiative will identify opportunities to streamline compliance activities for the nearly 5,000 accredited hospitals, allowing the organizations to pursue their efforts on improving patient care. The Joint Commission plans to conduct similar reviews for its seven other accreditation programs in the near future.

"Accreditation is about performance that directly impacts patient care and safety, not process and paperwork," says Charles A. Mowll, executive vice president, Joint Commission. "We want Joint Commission accreditation to continue to offer measurable benefits to hospitals and the patients they serve. A thorough, comprehensive assessment is crucial to ensure that Joint Commission standards accurately reflect the dynamic environment of health care today." Only a few recently established standards—such as groundbreaking requirements regarding pain management, patient safety and restraint and seclusion—are exempt from scrutiny. These standards have already been subject to the type of broad consensus-building efforts that the Joint Commission is now seeking for older requirements.

In addition, standards relating directly to Medicare Conditions of Participation (CoPs) for hospitals will receive special consideration. While the task force will identify potential additions, deletions or modifications to this subset of standards, the Joint Commission recognizes that these standards are the "law of the land" and are required for Medicare deeming. The task force's ideas, however, may potentially serve as the basis for Joint Commission discussions with the Health Care Financing Administration as changes are considered to CoPs.

Led by Ken Shull of the South Carolina Hospital Association, the task force will include quality directors, medical records directors, nurses, physicians, engineers, risk managers and other hospital leaders who have first-hand experience with Joint Commission accreditation standards and surveys. Furthermore, physician groups will be enlisted to specifically review medical staff standards.

"Many hospitals are faced with limited financial revenues, a national staffing crisis and an ever-increasing burden of compliance demands imposed by state and federal regulators, accreditors and managed care organizations," Shull says. "I welcome this invitation to work with my task force colleagues and the Joint Commission to offer constructive input on what most directly impacts patient care."

Specifically, the task force will consider the following criteria in reviewing standards:

> Continuing relevance in promoting patient safety or high quality care.
>
> Redundancy with other external quality requirements.
>
> Applicability of standards to hospital care.
>
> Likelihood that compliance will be consistently evaluated.
>
> Extent to which compliance can actually be measured.
>
> Linkage to patient outcomes.

The Joint Commission also will ask the task force to identify common misconceptions and misinformation regarding requirements for demonstrating standards compliance. These fallacies often result in unnecessary costs for hospitals in both staff time and resources.

In addition to the comprehensive standards review, the Joint Commission has in recent years made a number of significant changes intended to enhance the evaluation of critical patient safety and patient care functions and to achieve an accreditation process that remains consultative and centered on performance improvement. A redesigned on-site survey process now focuses more on individual-centered evaluations and allows more time for observation in patient care units. In addition, the Joint Commission is conducting pilot testing of a proposed model to assess staffing effectiveness and a more continuous survey process.

http://www.jcaho.org/news/nb324.html

APPENDIX F

The Joint Commission

Behaviors that Undermine a Culture of Safety

http://www.jointcommission.org/NewsRoom/PressKits/Behaviors+that+Undermine+a+Culture+of+Safety/app_stds.htm

Issue 40: July 9, 2008

Applicable Joint Commission Standards

Standard LD.03.01.01
Rationale for LD.03.01.01

Leaders create and maintain a culture of safety and quality throughout the [organization]. Safety and quality thrive in an environment that supports teamwork and respect for other people, regardless of their position in the [organization]. Leaders demonstrate their commitment to quality and set expectations for those who work in the [organization]. Leaders evaluate the culture on a regular basis. Leaders encourage teamwork and create structures, processes, and programs that allow this positive culture to flourish. Disruptive behavior that intimidates others and affects morale or staff turnover can be harmful to [patient] care. Leaders must address disruptive behavior of individuals working at all levels of the [organization], including management, clinical and administrative staff, licensed independent practitioners, and governing body members.

Elements of Performance for LD.03.01.01

1. Leaders regularly evaluate the culture of safety and quality using valid and reliable tools.

2. Leaders prioritize and implement changes identified by the evaluation.
3. Leaders provide opportunities for all individuals who work in the hospital to participate in safety and quality initiatives.
4. The hospital has a code of conduct that defines acceptable, disruptive, and inappropriate behaviors.
5. Leaders create and implement a process for managing disruptive and inappropriate behaviors.
6. Leaders provide education that focuses on safety and quality for all individuals. (See also LD.04.04.05, EP 6)
7. Leaders establish a team approach among all staff at all levels.
8. All individuals who work in the hospital, including staff and licensed independent practitioners, are able to openly discuss issues of safety and quality.
9. Literature and advisories relevant to patient safety are available to all individuals who work in the hospital.
10. Leaders define how members of the population(s) served can help identify and manage issues of safety and quality within the hospital.

Medical Staff Standard
MS.4.00

Overview

Determining the competency of practitioners to provide high quality, safe patient care is one of the most important and difficult decisions an organization must make. The development and maintenance of a credible process to determine competency requires not only diligent data collection and evaluation, but also the actions by both the governing body and organized medical staff.

The credentialing and privileging process involves a series of activities designed to collect, verify, and evaluate data relevant to a practitioner's professional performance. These activities serve as the foundation for objective, evidence-based decisions regarding appointment to membership on the medical staff, and recommendations to grant or deny initial and renewed privileges. In the course of the credentialing and privileging process, an overview of each and privileging process, an overview of each applicant's licensure, education, training, current competence, and physical ability to discharge patient care responsibilities is established.

Three new concepts are introduced in the revised credentialing and privileging standards. First, the revised credentialing and privileging standards have been informed throughout by the six standards have been informed throughout by the six areas of "General competencies" developed by the accreditation council for graduate medical education Education (ACGME) and the American Board of Medical Specialties (ABMS) joint initiative. The areas of general competencies include the following:

Patient Care

Medical/Clinical Knowledge

Practice-based Learning and Improvement

Interpersonal and Communication Skills

Professionalism

Systems-based Practice.

Integrating these concepts into the standards allows the organized medical staff to expand to a standards allows the organized medical staff to expand to a more comprehensive evaluation of a practitioner's professional practice.

APPENDIX G

Swinging Pendulum of Peer Review Immunity

By Charles I. Artz, Esq.

Physician's News Digest—Published November 2001
http://www.physiciansnews.com/law/1101.html

Recent appellate court decisions in Pennsylvania and other jurisdictions raise the question whether the immunity afforded hospitals and reviewers under the federal Health Care Quality Improvement Act (HCQIA) have allowed the peer review system to be improperly utilized, or even abused in some cases.

HCQIA was enacted by Congress in 1996 to provide immunity against civil litigation damages for physicians and hospitals engaging in professional peer review, and to restrict the ability of incompetent physicians to move from state to state without disclosure or discovery of prior damaging or incompetent medical performance. Immunity under HCQIA can be established if the peer review process meets four general standards:

> It had an objective, reasonable belief that its action furthered quality health care.
>
> It made an objective, reasonable effort to obtain the facts.
>
> Under the *totality of the circumstances*, the physician being reviewed received adequate notice and hearing (i.e., due process) procedures.
>
> The organization had a reasonable belief that its actions were warranted.

Superficial review of this four-part test suggests physicians should receive due process throughout the entire peer review, and serious quality of care issues must exist before a physician's privileges can be suspended, reduced or revoked. Case law and experience demonstrate the contrary.

Bias and Conflicts of Interest Immaterial

In *Manzetti v. Mercy Hospital of Pittsburgh*, the Pennsylvania Supreme Court held on July 18, 2001 that the hospital and reviewers were entitled to immunity under HCQIA. The Supreme Court disregarded all evidence relating to the reviewed physician's competitors' involvement in the case and attacks against him. The Court stated that any self-interest, bias or conflicts of interests by the reviewers were *immaterial*. According to the Court, the only time HCQIA precludes an economic competitor from involvement in the internal peer review process is at the hearing panel phase of the case; however, HCQIA does not preclude economic competitors from perpetrating due process violations and inculcating bias throughout the early phases of the review process. Under most hospital bylaws, by the time the physician gets to the fair hearing panel, the burden has shifted against the physician with the requirement that the physician prove by clear and convincing evidence that all prior decisions were arbitrary and capricious or factually baseless. Practical experience demonstrates this is a virtually impossible burden to sustain and standard to satisfy.

The Supreme Court also held that the "reasonable effort" prong of the four-part HCQIA immunity test is satisfied if the review activities are "sensible," but they do not have to be "flawless." Thus, the Supreme Court has countenanced due process violations and errors in the peer review process.

Sloppy, Negligent and Wrong Peer Review Warrants Immunity

In *Donnell v. HCA Health Services of Kansas, Inc.*, the Kansas Court of Appeals held on July 6, 2001 that physician peer reviewers are immune from liability under HCQIA even if their investigations are *sloppy, negligent, and wrong*. Physicians must prove bad faith and malice to have a peer review decision overturned.

This decision, like *Manzetti* above, allows a hospital to make serious mistakes about the quality of a physician's health care. It also permits termination of the physician's staff privileges, and the detrimental effect of a Data Bank entry, all with immunity from liability and practical impunity.

One Mistake and Done: Free Ride for Abuse

In Meyer v. Sunrise Hospital, the Nevada Supreme Court held on May 15, 2001 that a hospital's decision to terminate a physician based upon a single incident, regardless of the high quality of care the physician provided throughout the remainder of his career, was sufficient to protect the hospital under HCQIA's immunity provisions.

One Justice on the Supreme Court recognized the unfairness of the statute, but was compelled to uphold the decision. The Justice noted that HCQIA can sometimes be used, "not to improve the quality of medical care, but to leave a doctor who was unfairly treated without any viable remedy." That Justice also stated: "basically as long as the hospitals provide procedural due process and state some minimal basis related to quality health care, whether legitimate or not, they are immune from liability, which leaves the hospitals free to abuse the process for their own purposes."

No Constitutional Infractions

In *Freilich v. Board of Directors of Upper Chesapeake Health, Inc.*, a federal court in Maryland held on May 14, 2001 that the HCQIA immunity provisions do not violate due process or equal protection under the U.S. Constitution.

Review Must Be 100% Wrong?

In *Brader v. Allegheny General Hospital*, 167 F.3d 832 (3rd Cir. 1999), it was proven that the hospital's outside expert report had several incorrect conclusions. The Court of Appeals, however, ignored these mistakes because it found the report to be "otherwise thorough." The Court implied that the expert report must be entirely mistaken, and that the mistakes must be obvious. Because they were not, the hospital's decision was not unreasonable, and the first and fourth prongs of the HCQIA immunity test were satisfied.

Bias and Mistakes Early and Often Mean Nothing

In *Gordon v. Lewistown Hospital*, 714 A.2d 539 (Pa. Cmwlth. 1998), Commonwealth Court found that there is a presumption of validity of the hospital's disciplinary procedures. An outside consultant was retained. The Hearing Officer was an attorney, who was determined not to be in economic competition with the physician, but was a neutral party. Even though some of the physician's direct economic competitors were involved in the decision, and there was evidence of a history of hostility toward him, none of those individuals participated in drafting the outside report. The Court then looked to the *totality* *of the process* leading to the professional review action. Under that broad test, even though some parts of the process were critically flawed and biased, the Court said, in totality, the physician got all the process he was due.

These cases are the latest in a series of decisions nationwide leaving physicians who are subjected to peer review without any legal remedies, and without any right to secure a fair hearing and a fair outcome.

The Dreaded Data Bank

An "adverse action" following peer review results in the hospital reporting (through the Medical Board) the physician to the National Practitioner Data Bank, commonly referred to as the "Data Bank." Many reports conclude physicians' care was "incompetent," "unprofessional" or other professionally disastrous terms. Economic experts have opined that such a negative statement in the Data Bank directly results in substantial economic loss to a physician. The Pennsylvania Supreme Court in *Hayes v. Mercy Health Corp.*, 559 Pa. 21, 739 A.2d 114 (1999) stated that a physician's Data Bank entry may, if left unchallenged, have a deleterious effect on the physician's medical career.

Money and Vengeance

The author has represented orthopedic surgeons, cardiologists, OB/GYNs, thoracic surgeons, anesthesiologists, ophthalmologists, family physicians, internists and other specialists in hospital peer review cases and medical staff privileges litigation. More often than not in the author's experience, peer review is initiated against a physician for one of three reasons: (1) by economic competitors for financial reasons; (2) in retaliation against the physician for not "playing ball" in one manner or another (economic or otherwise); or (3) in retaliation for the physician raising concerns about other physicians' care and seeking to have those providers' outcomes reviewed. The state "whistleblower" law does not protect these physicians. The Pennsylvania Peer Review Protection Act, which allows physicians to litigate tort and contract breach claims in state court against hospitals whose peer review is effectuated by malice or bad faith, has been "trumped" (although not technically preempted) by the federal HCQIA immunity standards.

Shifting Sands

Hospital bylaws impose difficult legal standards and burdens on physicians. Typically, after a physician is the subject of an adverse recommendation or an adverse action by a medical executive committee, the physician is given a fair hearing. Traditional notions of fairness might lead one to believe that the hospital would have the burden of proof by at least a preponderance of the evidence to demonstrate the physician's quality of care was below some recognized and measurable standard warranting a quality of care concern. After al l, hospitals have a legitimate concern about corporate liability and "negligent credentialing" following the Supreme Court's *Nason Hospital* decision in 1991.

Absolutely every set of hospital bylaws the author has reviewed do not contemplate a truly fair system for the physician being reviewed. Instead of the hospital accepting the burden of proof with a reasonable standard based upon measurable guidelines for quality infractions, the bylaws shift the burden of proof to the physician and create a nearly impossible standard to overcome. The physician typically has the burden to prove that the hospital's decision was arbitrary and capricious. Some bylaws even state that the physician must prove that there was no material basis for the action or there was a complete absence of facts in the record to support the action. An utterly biased, sloppy, negligent and mistake-riddled report by an outside reviewer still cannot be overcome by this enormous burden if there is just a shred of truth in the report.

Practical Effect

As the case law outlined above illustrates, the physician's economic competitors and antagonists can initiate the peer review process, retain outside consultants and virtually direct the outcome of the report that will form the basis of the hospital's adverse action. After the antagonist's bias, conflict of interest, self-interest, direct economic competition and retaliation motives are all effectuated, they are immaterial and not reviewable by the courts, since all of those problems purportedly can be remedied by retaining a three-member independent panel to conduct the hearing.

Most fair hearing panels are truly independent. But, even if the panel calls "balls and strikes" fairly, the burden of proof and standard of review are so high it cannot be overcome practically. There is no legal remedy or recourse to the physician under the "totality of the circumstances" test. Hospitals have figured out that all they need to do is establish an independent fair hearing panel, give minimal due process at that final phase of the case, and their immunity will be intact.

JCAHO Doesn't Care

The JCAHO accreditation manual for hospitals contains medical staff standards. One standard requires "mechanisms, including a fair hearing and appeal process, for addressing adverse decisions for existing medical staff members and other individuals holding clinical privileges for renewal, revocation, or revision of clinical privileges." When discussing the broad HCQIA immunity and typical hospital bylaws burden shifting and standard setting procedures that are anything but fair and balanced, JCAHO staff take the position that they "don't care about detail" even if, as applied, the physician has no chance to overcome the standards.

Courts Don't Care

Although courts have no hesitancy involving themselves in the intricacies of physician practice in the context of medical malpractice liability, courts take a contrary view when physicians seek redress as a result of faulty peer review and retaliation. In *Lyons v. St. Vincent Health Center*, Commonwealth Court stated: "It is not up to the courts to second-guess hospitals in their decisions as to the best way to deliver services; it is up to the institution itself."

Early Intervention Strategy

A physician subjected to peer review may have little chance of surviving unless early and aggressive measures are taken. Understanding the case law and limitation on judicial remedies, it is prudent for the physician and counsel to quickly retain the best conceivable expert in the subject area to address the outside reviewer report. In many cases, it becomes very clear that the outside reviewer's report significantly overstates quality of care infractions, is based on no published peer reviewed medical journal articles or positions, and is academically pedantic without taking into consideration reasonable and acceptable standards of care.

Successful resolution using this strategy can be achieved with minimal disruption to the physician, including perhaps CME and monitoring, without causing a damaging Data Bank entry.

Statewide Independent Peer Review

The process described in this article has led many physicians, and some organizations, to propose a statewide peer review requirement that would utilize independent, non-biased peer review organizations that make judgments based upon clearly acceptable standards, taking into consideration reasonable differences of opinion. Like a physician being judged for a licensure infraction, the burden of proof would remain on the entity seeking to impose discipline (the hospital) with at least a preponderance of the evidence standard, if not a clear and convincing standard. Only this level of independence would balance the playing field and return quality of care to the forefront of peer review.

Charles I. Artz, Esq., is the founder of the law firm Charles I. Artz & Associates, located in Harrisburg, Pa.

APPENDIX H

OVERTREATED

Why Too Much Medicine Is Making Us Sicker and Poorer

Shannon Brownlee

BLOOM SBURY

Some names have been changed to protect the privacy of others. Copyright © 2007 by Shannon Brownlee "Afterword: Sharing Decisions" © 2008 by Shannon Brownlee All rights reserved. No part of this book may be used or reproduced in any manner whatsoever without written permission from the publisher except in the case of brief quotations embodied in critical articles or reviews. For information address Bloomsbury USA, 175 FifthAvenue, New York, NY 10010. Published by Bloomsbury USA, New York All papers used by Bloomsbury USA are natural, recyclable products made from wood grown in well-managed forests. The manufacturing processes conform to the environmental regulations of the country of origin. The Library Of Congress Has Cataloged The Hardcover Edition As Follows: Brownlee, Shannon. Overtreated: why too much medicine is making us sicker and poorer / Shannon Brownlee.—1st U.S. ed. p. cm. ISBN-13: 978-1-58234-580-2 (hardcover) ISBN-10: 1-58234-580-2 (hardcover) 1. Medical care—United States. 2. Medical care—Utilization--United States. I. Title. RA395.A3B785 2007 362.10973—dc22 2007021968 First published by Bloomsbury USA in 2007 This paperback edition published in 2008 Paperback ISBN-10: 1-58234-579-1 ISBN- 13: 978-1-58234- 579-6 I 3 5 7 9 10 8 6 4 2 Typeset by Westchester Book Group Printed in the United States of America by Quebecor World Fairfield

botched several sex-change operations and cut off the wrong leg of a man who subsequently developed gangrene and died. An orthopedic surgeon became fixated on doing more surgeries than any other physician in his group, sometimes working eighty hours a week to keep up his productivity. The more surgeries he did, the sloppier he got, until he was routinely committing errors and getting sued for malpractice. In one case, he put in the wrong size screw to repair a patient's bone and refused to correct it when the head of the screw poked through the patient's skin. It's tempting to lay all medical error at the feet of bad doctors, but that can't be the whole story, as Harvard surgeon Atul Gawande points out, for the simple reason that good doctors make mistakes too. Studies of specific types of medical error suggest that it is not just a small subset of doctors who commit them, a rotten few who are responsible for all the problems. Rather, every physician is destined to make at least one horrible mistake in the course of a career—and most will carry the memory and shame of it for the rest of their lives. It isn't just doctors who err. Virtually every person who has direct responsibility for the care of sick people falls down on the job sometimes, and the more people involved in an individual patient's care—and the more procedures the patient undergoes—the more likely it is that somebody in the medical supply chain is going to blow it. Just think for a moment about the sheer number of people who have a hand in whether a patient lives or dies. There are the orderlies who must deliver blood samples to the lab on time and the pathologists who must correctly identify infectious agents so doctors can prescribe the right antibiotic. Pharmacists have to provide the right drug at the right dose to the right patient. Somebody has to scrub down every bacteria-harboring nook of an operating room, thoroughly sterilize equipment and linens, stock supply closets, fill soap dispensers, and maintain heart monitors and ventilators. Every single person must do his or her job right every single time or risk the well-being of patients. When you think about how many people touch a patient, either directly or indirectly, and how many tasks they must perform with precision in order to keep patients safe, it' s hard not to wonder how patients ever leave at all.

THREE Your Local Hospital 72

To REACH SHASTA Regional Medical Center, just drive north from San Francisco on Interstate 5 for four hours, until you see Mount Shasta, floating over Siskiyou County in its permanent cloak of snow. The hospital sits in the middle of downtown Redding, near a bend in the winding Sacramento River. Known as Poverty Flats in the early nineteenth century, Redding was first settled by miners and loggers, who stayed until the mines were tapped out and the redwoods and pines were all cut down. The town revived in the mid-twentieth century. When it became a mecca for fishermen, hikers, and skiers headed for nearby Shasta and Trinity lakes, Lassen Volcanic National Park, and snowcapped Mount Shasta. Tourism is now one of two main businesses in this town of ninety thousand residents. Between them, Shasta Regional Medical Center and Mercy Medical Center employ more than two thousand people, and generate nearly one hundred million dollars a year in revenue. Dr. Patrick Campbell arrived in Redding with his wife and two children in 1993 less than two years out from his internship and residency at the University of California, Davis.

Campbell had been working in an urgent care facility in Sacramento when he was recruited by Redding Medical Center (which would be renamed Shasta Regional Medical Center in 2003). Redding offered a two-year salary guarantee, which would give Campbell time to build a practice and payoff medical school debts. From the hospital's perspective, good relations hips with primary care physicians like Campbell were a matter of branding, well worth the recruitment costs: primary care doctors who were loyal to Redding Medical would admit patients to the hospital and refer them to the hospital's specialists, especially those in its busy cardiac program. To Campbell, Redding seemed to offer a good life. The crime rate was low, the schools were good and the area was beautiful. He could have a small-town practice that would let him get to know his patients over the years, while still having access to a modem, high-tech hospital. Campbell's high hopes and idealism at the outset of his career made the events that would unfold in Redding over the next decades the lawsuit he would file in 2002, the evidence of malpractice and fraud committed by several heart specialists at Redding Medical that he would uncover, and the town's anger at him for exposing two of its most prominent physicians seem all the more surreal. After blowing the whistle on the hospital and its specialists, he would lose practically everything he valued, his medical practice, his family, and his home. The tale of Campbell and Redding Medical Center tells a larger story about the forces that drive all hospitals to deliver unnecessary care—and how difficult it is to rein them in. Campbell grew up in Portland, Oregon, the son of a secretary and a customs inspector, the first person in his family to go to college. An accomplished violist in high school, he entered Levis and Clark College with a full music performance scholarship. But after two years of college and a move to California, the early dream of an orchestral music career faded. He enrolled at the University of California, Santa Cruz, and switched to natural sciences. After an undergraduate degree in chemistry and three years as a graduate student, he finally settled on medicine, enrolling in medical school at the University of California, Irvine, where he met his wife. Both Campbell and his wife went into primary care. an idealistic decision at a time when more and more of their classmates were choosing to enter specialties where the money was much better. One of the first doctors Campbell met in Redding was a cardiologist, Chae Hyun Moon. The son of a Korean physician, Moon was a more ambitious breed of doctor. According to the New York Times, he graduated in 1972 from the College of Medicine at Yonsei University in Seoul and completed an internship and residency at Metropolitan Hospital Center in New York.

His forceful personality and constant availability allowed him to quickly build a thriving practice in Redding. When Moon arrived in northern California in the early 19805, all invasive cardiac services-cardiac catheterization, angioplasty. and open-heart surgery—were being done in bigger cities like Sacramento, two hundred miles away. Moon pushed for a cardiac catheterization laboratory—a special room containing the equipment needed to perform such procedures as balloon angioplasty—and open-heart-surgery capability in Redding. First Mercy Medical

Center and then Redding Medical opened labs, followed by an open-heart-surgery program, in 1987. Five years later, Moon and Fidel Realyvasquez, Jr., a Stanford-trained cardiothoracic surgeon were the dominant figures in their respective specialties. Together, the men built the California Heart Institute within the once-sleepy Redding Medical Center. Primary care physicians sent their patients from all over northern California, from tiny towns like Weed and Paradise, and from as far away as southern Oregon. Moon was always willing to accommodate another patient. As he would later tell the Sacramento Bee. "When these guys call me up day or night or holidays, it doesn't matter. I am in a health profession to save lives." Both heart specialists were workhorses, but Moon especially so. He focused his practice on catheterization, an invasive procedure that involves snaking a thin catheter, or tube, up through a major blood vessel in the groin into the coronary arteries, the blood vessels that supply the heart muscle with oxygen. Moon also performed balloon angioplasties, threading a tiny balloon up a wire inside the catheter. When the balloon was inflated, it could smash a clot against the arterial wall, allowing blood to flow freely once again. By the 1990s, cardiologists were also employing stents, tiny mesh tubes that could prop open a blockage inside a coronary artery. Moon sometimes performed as many as a dozen cardiac catheterizations in a sing le day-four to five times the number his peers in northern California were performing. In one year, he performed more than eight hundred invasive cardiac procedures. Between June 2001 and 2002, he billed Medicare for four million dollars. At its peak, Redding Medical Center was Performing nearly eight hundred open-heart surgeries per year—many of them done by Realyvasquez.

With the enormous volume of procedures came high incomes and lavish lifestyles. Moon owned a rambling hilltop estate on the west side of Redding, with a view of Mount Shasta and No Trespassing signs posted at the bottom of the driveway. Realyvasquez lived on the east side, at the end of a tree-lined street behind an electronic gate. The doctors were popular figures in town. Realyvasquez donated his collection of fifty original Ansel Adams prints to a local museum. For eight years, Moon donated five thousand dollars annually to a scholarship for Shasta High School graduates interested in science or medicine. In a letter to the editor of the Redding Record Searchlight, the local paper, a resident wrote, "How lucky we have been that Dr. Moon chose this country to practice in." In the summer of 1993, a new patient, Mary Rosburg, came to Patrick Campbell with a multitude of physical complaints, including mild chest pains and shortness of breath. Rosburg and her husband spent summers living in their trailer in Trinidad, a small resort town on the California coast, just north of Eureka. Because she was having chest pains, Campbell gave Rosburg, who was in her sixties, a stress test, which involved asking her to walk on a treadmill while hooked up to a cardiac monitor. The test was inconclusive, but out of an abundance of caution, he referred his patient to Moon. Campbell assumed that the specialist would "work up" Rosberg that is, give her a series of mildly invasive tests, including another kind of treadmill test, that would help determine whether her complaints indicated heart disease. Instead, Moon went straight to a coronary artery catheterization and promptly declared that she needed immediate bypass surgery and a heart valve replaced. Campbell was surprised both by the speed with which Moon used catheterization and by the diagnosis, but he assumed the cardiologist knew best. Later that same day, however, Campbell got another call, from a young cardiovascular surgeon who was a newly arrived partner of Realyvasquez's. In that doctor's opinion, Rosburg did not need surgery. Campbell was startled, but as a primary care physician just starting out in the community, he didn't feel he was in any position to quest ion Moon's judgment. He suggested the surgeon talk to Moon directly. The next morning, Campbell's patient under-went the operation. Her recovery was uneventful, hut several weeks later, while in Trinidad with her husband, Rosburg abruptly developed severe chest pain and shortness of breath. Flown back by helicopter to Redding, she was found to have a large blood clot on her new heart valve and underwent emergency surgery that night to replace it. Rosburg went into acute kidney failure and died within a week. Shaken by the death of a patient who had been essentially healthy just three months earlier, Campbell wondered if perhaps the surgeon who had called him had been right-that Moon's diagnosis had been incorrect. He concluded that he was in no position to review the records independently, and the surgeon in question left the area after one year. But after witnessing further examples of Moon's quickness to send patients to the cath lab and recommend open-heart surgery. Campbell began to worry in earnest that Moon and his group were being far too aggressive in their management of cardiac patients. Two years later, Campbell would have hard evidence that patients were being given unnecessary care by the cardiologists in Moon's practice. During a routine office visit, Emma Jean Montgomery complained to Campbell about chest pain. Campbell reports that he sent her to one of Moon's partners. The cardiologist performed a stress test, then catheterization, and told Campbell by phone that the patient had severe, three-vessel coronary artery disease and needed immediate bypass surgery. The surgery was done the next day. When Campbell received the written report from her catheterization, two months after her surgery, he was shocked to see that the cardiologist had indicated that the patient had only mild to moderate coronary artery disease and that her chest pain was not caused by her heart. Not knowing which version to believe, Campbell obtained the images of her heart that were taken during her procedure and looked at them with Dr. Roy Ditchey, a local, board-certified cardiologist who had just relocated to Redding. Campbell says that Ditchey agreed: The woman's coronary arteries were not severely blocked, and she had not needed surgery More than once, Campbell and other physicians who were concerned about the hospital's cardiology program and its doctors would complain to Redding Medical Center administrators. At least once, a review was promised.

but over the years, as far as Campbell could tell, one was never actually undertaken. In the end, Redding Medical Center would be forced to shut down its cardiac program, after Campbell finally succeeded in alerting the Federal Bureau of Investigation and the Department of Justice. Medical records seized from the hospital were given to several outside heart specialists, who found that in twenty-seven years at Redding, Moon had catheterized some 35,000 patients, a huge number for just one physician working in a lightly populated, largely rural area. In the opinion of the outside specialists, between one quarter and one half of the patients who underwent catheterization or surgery at Redding Medical Center had been operated on inappropriately. Justice Department documents stated that at least 167 patients had died during cardiac surgery, or shortly after, as a direct result of the Redding doctors' aggressive treatment. Either the patients had been too weak to withstand the surgery, or the doctors had been negligent, or they had committed errors, sometimes in haste to go from one patient to the next. In May 2006, the California State Medical Board moved to revoke Moon and Realyvasquez's licenses. By then Redding Medical's parent company, Tenet Healthcare Corporation, had agree to pay $59.5 million to the federal government to settle charges of Medicare fraud, at the time the largest settlement made by a health care company. A flurry of news reports appeared across the country, tracking the spectacular fall of Redding Medical Center. Most of the articles interpreted the events as an exceptional example of doctors run amok, or an isolated case of Medicare fraud, or an especially egregious episode in the ongoing saga of for-profit health care. But the story of a small hospital in northern California symbolizes a flaw in American medicine that goes far deeper—and is shared by nearly every sing le medical institution in the country.

No margin, no mission

The one concept that the media missed in covering the events at Redding Medical Center was that most hospitals deliver unnecessary care. As patients, we want to believe that places like Redding and doctors like Moon and Realyvasquez represent the rare case, and that a for-profit hospital so busy making money that its administrators did not want to acknowledge what was going on in their cardiac center is the exception, not the norm. Unfortunately, Redding Medical and its doctors were simply outliers at the far end of the spectrum of useless, unnecessary and potentially dangerous care that hospitals provide (even as they simultaneously fail to deliver other kinds of care that patients need). Unnecessary care, it turns out, is inevitable in a health care system like ours, partly because of the way hospitals are paid. All hospitals need to make money, and for the most part, as we've seen, hospitals and the physicians who work in them get reimbursed for how much care they deliver, rather than how well they care for patients—let alone how efficiently they deliver that care. When hospitals and doctors give patients medical procedures and tests they don't need, or when they fail to give patients care they do need, they are responding to the perverse incentives built into the byzantine and often—precarious reimbursement system that keeps them all afloat. In the days before health insurance and Medicare, most hospitals were run by religious charities, which operated under the motto "No margin, no mission." Their mission, of course, was tending to the sick, regardless of the patient's ability to pay; they tried to earn a small margin on the patients who could pay in order to cover the cost of their mission. Today, hospitals still need to run a profit to stay open, even nonprofits, which make up more than three quarters of the more than five thousand hospitals in the United States—and most still turn to paying (or insured) patients in order to do so. From the humblest rural clinic to the most prestigious academic center, nonprofit hospitals generally earn at most between 2 and 6 percent profit on annual revenues, in part because forty-seven million Americans under sixty-five, or about one in six of us, have no health insurance. At most nonprofits, about 3 to 5 percent of patients are uninsured; at public teaching hospitals, it's a whopping 15 to 20 percent. In 2003, hospitals reported losing twenty-five billion dollars providing care for which they received no compensation. (Outside researchers suggest hospitals may be inflating their losses, which may be closer to sixteen billion dollars.)

OVERTREATED 84

With its ideological preference for market-driven solutions. the Reagan administration was not about to approve price controls on hospital payments. Instead, the president signed a plan to impose the DRG system, an entirely new, draconian payment plan intended to create incentives for efficiency and reduce the number of details over which government and hospitals could quibble. The fee for each diagnosis group is set to reflect the average cost of treating that condition in an efficient hospital. If a patient is sicker than average and requires extra care, the hospital eats the difference. If the patient is healthier than average, or the hospital gets him back on his feet more quickly than average and he consequently costs less than average, the hospital gets to keep the change. The DRG system succeeded in providing a market incentive for efficient hospitals to make a small profit, while forcing inefficient hospitals to cut expenses. Many hospitals responded by shutting down excess beds and slashing their lengths of stay, which had stretched out during the cushy cost-plus years. The system slowed the rate at which Medicare spending was rising to 8.6 percent between 1983 and 1984, the smallest annual increase since the program began. The following year the rate of increase dropped to 5.5 percent. (The rate of increase for hospital payments went to zero the year that Redding Medical Center's shenanigans came to light. with hospitals bending over backward to avoid overcharging Medicare.) But the DRG system also had an unexpected side effect, one that has helped drive the delivery of unneeded care in certain branches of medicine. Even though DRG fees are supposed to reflect actual costs. in reality they overpay for many procedures, especially many surgeries. At the same time, they underpay for other kinds of care. Take cardiac bypass, an exceptionally profitable surgery. in 2002, Medicare paid $24,000 per bypass surgery with cardiac catheterization while the average cost per case, according to a report put out by the Medicare Payment Advisory Commission (MedPAC), was $ 14,400, leaving $9,600 profit for every bypassed patient. Other cardiac procedures offer even higher margins: Replacing a heart valve, the surgery Patrick Campbell's patient Mary Rosburg underwent, can yield as much as 60 percent profit. The net profit hospitals make from these procedures drops when Medicare patients are sicker, of course, but even so, the most common cardiac procedures typically performed on a heart attack patient earn about 6 to 16 percent over costs from Medicare reimbursement and more than one hospital has made its entire margin on invasive cardiac procedures alone. Most private insurers don't use the DRG system, but rather a combination of negotiated payments and per diems that wind up being more generous in some markets than Medicare—and they too overpay on many procedures. From private payers, hospitals can reportedly make around $ 20,000 for an angioplasty procedure, about 40 percent of which is profit. On the flip side of the profit equation, the DRG payment for treating a heart attack patient with drugs alone and no surgical intervention—which for many patients is just as effective—produces about an 11 percent loss for the average hospital. What all this means is that any hospital administrator with an ounce of good business sense is going to want to maximize the number of patients in profitable service lines, which they have taken to calling "centers of excellence," whether or not they are, in fact, excellent. Even at academic medical centers, administrators exert subtle pressure on the physicians working in profitable departments to keep up their productivity by performing more-profitable procedures. In this sense, a hospital is no different from any other business. In recent years, IBM has shifted its focus from selling hardware to servicing large database systems where profits are higher. An even better analogy for the hospital industry is a low margin, high-volume business like personal computers. Dell earns only about 5 percent profit on each computer it sells, but it sells millions and millions of them. Similarly, hospitals want as many "bed turns:" or as much "throughput," as possible in their profitable departments. The best way to accomplish this is to expand the capacity of high-margin departments to increase volume. You can think of it as the Willie Sutton strategy: Willie Sutton robbed banks because that's where the money is; hospitals invest in their moneymaking product lines because that's where the profit is. Yet, when hospitals focus not on profits but instead on providing care that helps patients, they often wind up being punished financially Several hospitals around the country have experimented with integrated, supportive

Your Local Hospital 87

Investing in profit, not health. All of this goes a long ways in explaining why, in 1998, Redding Medical Center decided to expand its moneymaking product line—the cardiac procedures being performed by Realyvasquez and Moon. That year, the hospital earned $50 million in pretax profits, most of it from the California Heart Institute. "We were beyond full: one former administrator would later tell the New York Times." We were flying. The hospital constructed a five-story addition, known around town as "the Tower," much of which was devoted to expanded cardiac facilities. The Tower allowed Moon and Realyvasquez to recruit other cardiologists and surgeons to the area-and to bring in more patients. The cardiology specialists were not actually employed by the hospital; they had private practices and what's known as "admitting privileges," a relationship that is beneficial to both physician and hospital. Once known as the "doctor's workshop," a hospital is a little like a hotel filled with nursing staff, technology, and beds, where physicians are granted the privilege of admitting and treating patients. For hospitals, doctors are the medical equivalent of rainmakers in a law firm, the people who bring in the paying customers and most hospitals bend over backward to attract and keep physicians who can bring in patients who are insured. “Hospitals need to understand who their customer is—the doctor who admits patients,” as one neurosurgeon aptly puts it. With so much riding on the cardiac team, Redding administrators and the hospital’s parent company, Tenet Healthcare, stroked and pampered Moon and Realyvasquez. The hospital appointed Realyvasquez chairman of cardiothoracic surgery and made Moon chairman of the cardiology department. Moon was also a member of the hospital board, and was eventually made head of the committee charged with overseeing the quality of cardiac care. The hospital sponsored golf tournaments to benefit the cardiac unit, sometimes offering Moon the use of its emergency helicopter to fly to the golf course. Moon’s success and prestige gave him unusual clout for a physician; at one point, he was instrumental in persuading Tenet to dismiss a hospital executive. “No one would ever want to take [Moon] on,” a former Redding administrator told the New York Times. “Moon was Redding Medical Center, and he knew it.”

By ‘999, Campbell had stopped sending patients to Moon if he could avoid it. He left his group practice and moved to another office, preferring to send his patients to Mercy Medical Center, the hospital across town. Still, he felt compelled to call attention to the situation at Redding. He strongly suspected that Moon, Realyvasquez, and their colleagues may have been charging Medicare and Medi-Cal, the state’s Medicaid program for unnecessary procedures, not to mention putting patients at terrible risk. In March, he approached a local Redding attorney, asking his advice about how to get the government to investigate the hospital and its cardiac team. The attorney, Jerrold Pickering, a longtime Redding resident who was a patient of Campbell's at the time, listened to the doctor's story for two hours before promising to look into the matter. Over the next two weeks, Pickering made several confidential inquiries to local Medicare officials, outside physicians, and the local district attorney's office. The lawyer then wrote Campbell a letter, telling him that the public authorities were not interested in pursuing the case. "The Medicare people shuffled around and around ... and were not really interested unless someone handed them a case fully worked up, "he wrote. The district attorney was equally disinclined to pursue the issue, according to Pickering, even after he mentioned the death of one of Campbell's patients. Several of the people Pickering contacted knew about the problems at Redding Medical Center, wished any whistleblower well, but "would undoubtedly disappear when the first shot was fired. The conclusion is inescapable: Do not blow any whistle! Period. Rationale for this is: (1) you would be very alone, (2) there is too much money involved, (3) except for the victims and/or their families, no on e cares, and (4) you would instantly find yourself with a bunch of new vigorous enemies." Several of those predictions would turn out to be painfully accurate for Campbell, who ignored the lawyer's advice and continued to search for a way to get Medicare to pay attention. Later that year, he came across an article in the magazine Medical Economics about a successful physician whistleblower and the federal False Claims Act, which is intended to encourage employees of companies that do business with the federal government to report fraud and abuse. Campbell called the physician, who referred him to a New York law firm that specialized in whistle-blower-cases. The firm told Campbell he needed more cases to persuade the government that there was a serious problem worth investigating. But Campbell was unable to get other Redding physicians to produce any cases, even physicians who in private complained about Moon, Realyvasquez, and Redding Medical Center. By the summer of 2001, Campbell was deeply discouraged. He'd exhausted every option he could think of for alerting the authorities. His wife was fed up with his obsession, and he still had a busy primary care practice to tend to. A year later, Campbell got word that an FBI agent was nosing around town, asking questions after a few patients or their families had complained to the agency about the cardiac program. Throwing his lawyer's advice to the wind, Campbell called the agent. That was on a Thursday afternoon in August; the next morning he was sitting in the agent's office in Redding. Worried that the FBI agent would not believe him, Campbell arrived with over sixty pages of documents. After showing the agent his material, Campbell steered him to a nurse and two other physicians, who would eventually back up his claims that Redding's cardiac team was performing necessary cardiac procedures. On October 30, 2002, the FBI filed a sixty-seven-page search warrant affidavit with a judge, based largely on Campbell's information. That same day, more than forty agents from the FBI and the federal Department of Health and Human Services showed up without notice at Redding Medical Center and the doctors' offices and seized thousands of patient records and other evidence. Two weeks later, the stock price of Tenet Healthcare had tumbled from nearly fifty dollars a share to fifteen dollars. The

Justice Department's outside experts and a cardiologist hired by the state medical board would find a pattern of unnecessary and sometimes negligent care that represented "an extreme departure from standards of medicine," according to one physician who reviewed the records. In one case at Mercy Medical Center in 1996, Moon left a sixty-seven-year-old man who had suffered a massive stroke on the catheterization table, in the care of nurses without adequate instructions, and returned to his office. The man died soon thereafter. Moon would later defend his actions by saying he had done everything he could by picking up the phone and calling in a neurologist and a critical care specialist. When brought before peer review committees at Mercy to explain his actions, Moon fought back, ultimately filing lawsuits in state and federal courts against the hospital. The suits were eventually dismissed. Other patients of Moon and Realyvasquez survived but suffered long lasting, debilitating effects from their unnecessary surgeries. A local rancher named Stephen Hunt was only thirty-eight years old when he walked into the emergency room at Redding Medical Center just before Christmas in 2001, complaining of blurry vision in one eye. Hunt knew he had high blood pressure, but he was shocked when Moon told him he needed immediate bypass surgery—that he could suffer a heart attack and die on his way back to his car. Moon also told him there just happened to be an opening in the hospital's operating schedule on Christmas Eve. Hunt went ahead with the surgery. When the Justice Department gave Hunt's medical records to outside cardiologists, they found no evidence that the surgery had been needed. Hunt's blurry vision cleared up once his blood pressure was successfully treated with drugs, but his life would never be the same after his surgery. He suffered a hernia at the incision site, which meant he could no longer do the physical labor of ranching: the fencing, bucking hay, and moving cattle. Five years later, he lost his ranch. On August 4, 2003, Tenet Healthcare Corporation agreed to pay $54 million to settle fraud charges brought by the federal government. In return, Redding Medical Center and Tenet were granted immunity from criminal prosecution. Ultimately, Tenet paid nearly $60 million to settle federal fraud allegations. and the Department of Health and Human Services permanently banned Redding Medical Center from receiving Medicare. Tricare (which insures members of the military), or Medi-Cal payments, effectively forcing Tenet to sell its former flagship hospital. The company eventually agreed to pay an additional $395 million in restitution to more than 769 patient s and their families who sued the company. In all, Tenet would pay the federal government more than $900 million to settle charges of unlawful billing practices at Redding and other hospitals. Shareholder lawsuits amounted to $ 2 15 million. In January 2003, Moon voluntarily suspended his practice. The California State Medical Board opened an investigation.

Moon and Realyvasquee agreed to pay $ 1.4 million each in fines to the federal government, in lieu of criminal prosecution, while their Medicare billing privilege s were revoked. There are many lessons to be drawn from the story of Redding Medical Center, beyond the obvious fact that physicians don't like to point fingers at colleagues, even when their reticence allows patients to be harmed. But perhaps the most important lesson concerns the powerful effect that distortions in the reimbursement system can have on the decisions that hospital administrators make about how to invest capital resources. These distortions, coupled with policies dating back before the beginning of Medicare that built up the number of hospital beds until the early 1980s, have conspired to leave some cities, or parts of cities, with a surplus of certain kinds of beds and facilities—while simultaneously creating a shortage of others. In Los Angeles, for instance, there are two and a half times more intensive care unit beds per Medicare recipient than there are at the renowned Mayo Clinic, in Rochester, Minnesota, where nobody would argue that patients get substandard care. The result of this surplus of ICU beds in Los Angeles has meant that doctors are more likely to put patients in the ICU, whether or not they really need to be there. This kind of overinvesunent in profitable service line s can be seen in cities and towns across the country, in New York, Miami, and Los Angeles especially—precisely the cities where Jack Wennberg's group has found the highest rates of unnecessary care. We all wind up paying for it, as this overinvestment drives up costs for Medicare, state Medicaid programs, and private insurers. Meanwhile, more than a hundred emergency rooms around the country have closed in the past decade, victims in part of rising rates of uninsured patients appearing at their doors. At hospitals that have kept their emergency doors open, administrators have not been eager to add the additional ER beds that are often so desperately needed, because that would mean caring for more uninsured (and unprofitable) patients. Many cities now face a shortfall of emergency services, and hospitals routinely divert ambulances because their emergency departments are completely full. In Cincinnati, for example, diversions were so rare before 1998 that the city didn't even track them. By 2002, the total amount of time the city's hospitals were on divert status had jumped to 1,970 hours annually, and the problem just keeps getting worse. In the month of December 2003 alone, emergency rooms were on divert status for 1.935 hours. That's the equivalent of nearly eighty-two days. I caught up with Patrick Campbell in June 2006, when he was living in Eugene, Oregon pulling twelve-hour shifts as a hospitalist overseeing the care of patients admitted to Sacred Heart Medical Center. When I spoke with Campbell over the phone, he recalled the events shortly after the FBI's 2 0 02 raid in a tone of voice that veered between incredulity and resignation. "I remember a day after the raid, I had to go see a patient over at [Redding Medical Center], and people were looking at me with hatred," he said. "Within a week, everybody in Redding knew who had talked to the government, even though I was identified on the FBI affidavit only as 'D I.' "Stories appeared in the Redding Record Searchlight, reporting expressions of outrage among the local citizenry-not at Moon and Realyvasquez's alleged perfidy, but rather at their persecution by the federal government. The paper quoted Rhonda Arnold, a medical assistant in Moon's office, saying, "I've never met a man as honorable as Dr. Moon." Colleagues of the doctors said it was an injustice that patients would be "cardiac cripples" if not for Moon and Realyvasquez. On November 8, 2002, nine days after the raid, Campbell filed a qui tom (whistleblower) suit with the u.s. district court, in Sacramento. A qui tam lawsuit is typically filed by a private party, alleging fraud against a federal agency. If the Justice Department investigates and the fraud is proved, it enables the government to recover up to triple damages and substantial penalties from the defendants—while the whistle-blower can potentially receive a portion of the government's recovery. By then, Campbell was pretty sure he was going to need the money to start over in another town. Patients had left his practice; colleagues avoided him. The town of Redding was angry with him. The state medical board would initiate, and ultimately drop, disciplinary proceedings against him, putting hi s medical license at risk, after a patient complained that Campbell had given the patient's confidential Your Local Hospital 93 records to the FBI without consent. His popularity did not improve when the hospital began laying off employees. At one point, a group of nurses threatened to sue him for loss of employment. In June 2003, eight months after the raid, Campbell was stunned to learn that the Justice Department had moved to dismiss his whistle-blower suit in favor of another qui tam suit that had been filed just three days before his. The first-to-file whistle-blower was a Catholic priest named John Corapi, who had gone to Moon in June 2002 for what he thought was a routine cardiac checkup and had been told, like so many of Moon's patients, that he would die without immediate surgery. Unlike many patients, Corapi got a second opinion- in Las Vegas, where an old college buddy, Joseph Zerga, was an accountant. The doctors there told him that he had no significant coronary artery disease. When Corapi and Zerga complained to the Redding Medical Center CEO and got the brush-off they went to the FBI. The priest's legal standing as a whistle-blower was questionable. The Justice Department was suing Tenet Healthcare and the doctors on behalf of Medicare; Corapi, who was in his fifties, wasn't old enough to be a Medicare recipient. The priest's contribution to the FBI's investigation consisted only of his own medical records; he had no personal knowledge of any other cases, and his case involved only an unnecessary cardiac catheterization and a recommendation for bypass surgery. The sixty-nine pages of documents that Campbell plunked down on the desk of the FBI agent, by contrast, contained case histories covering a ten-year period; a record of Redding Medical administrators' ignoring multiple efforts to bring Moon and Realyvasquez's actions to their attention; names of physicians and a nurse who could corroborate his story; and even a glossary of medical terms. Even so, the Justice Department took the position that Corapi and Zerga were the sole whistle-blowers, because they beat Campbell to the courthouse. In August, the court granted the Justice Department's motion to throw out Campbell's qui tam suit and subsequently enter into the $54 million settlement with Tenet Healthcare. Meanwhile, Corapi and Zerga stood to receive the entire 15 percent of the settlement owed to a whistle-blower, worth more than $8. 1million.

It would take more than two years for Campbell and his lawyer to get the Justice Department's decision to remove him as a whistle-blower reversed. In the meantime, Campbell's practice In Redding dried up completely. His marriage foundered—"J wasn't the easiest person to live with," he said and in 2005, he left his wife and two children In Redding and moved to Eugene. When his lawyer filed an objection to the

Justice Department's decision, assistant U.S. attorney Michael Hirst, the prosecutor in the case, accused Campbell of being "driven more by greed than indignation." The prosecutor praised Corapt and Zerga, saying publicly, "Their willingness to blow the whistle on fraud resulted in our putting a stop to the surgeries and recovering $54 million." "That was a low point," Campbell told me. "It played out in the local paper as a battle between competing whistleblowers, a doctor and a priest, ducking it out in the courts." In November 2005, the court reinstated Campbell's qui tam suit and he agreed to settle for half of the whistleblower bounty, giving him nearly $4.5 million, before taxes and attorney's fees. Seven months later, in 2006, his wife and kids were driving up from Redding for a visit over the Fourth of July weekend. Campbell had not decided what he would do next. In the weeks leading up to the settlement, he had imagined that it would bring some sort of relief, a sense of closure, and maybe even a small measure of vindication. But when I spoke with him, Campbell sounded tired. Some days, he said, he thinks he will set up a new practice in Eugene or elsewhere; on other days, he wants to abandon medicine entirely and embark on a new career. Neither Moon nor Realyvasquez has ever admitted any wrongdoing. Shortly after the raid. Moon appeared genuinely devastated by the charges. Telling reporters his only goal had been to keep his patients safe from heart disease. He wept when a group of supporters strung up a banner that said, WE SUPPORT OUR DOCTORS! outside the courthouse. Maybe Moon and Realyvasque2 and the hospital were deliberately bilking Medicare, as the Justice Department's charges against them indicate. Or maybe, as Moon and Realyvasquez claim, they were making judgment calls within the wide latitude Your

Local Hospital 95

permitted by the art of medicine, the uncertainty of cardiology. If that's the case, then the saga of Redding Medical Center points to the desperate need in medicine for clearer standards and better evidence for what works and what doesn't. The story of Redding also highlights the need fat a new way to pay doctors and hospitals, a system that doesn't allow financial imperatives to propel clinical decisions.

OVERTREATED 278

Too many patients. Give them the time to practice preventive medicine. (VHA primary care doctors are responsible for about fifteen hundred patients, at least five hundred fewer than the average internist or family physician.) Use information technology to improve coordination among doctors. Make hospitals and doctors accountable by measuring their performance and the outcomes of their patients. And finally, gather evidence for what works and what doesn't. We could call this strategy CARE, for coordination, accountability, electronic medical records, and evidence. While the tasks are clear, implementing CARE around the country won't be simple. In order to do it, we have to rethink the way we pay doctors and hospitals. The first step is for Medicare to address the way it overpays for certain procedures, like radiology and bypass surgery, and underpays for less-intensive care. The current system encourages hospitals to invest in expensive doctors and beds and technology that aren't necessary-ly what patients need. But there are other ways the payment system makes it hard for doctors to coordinate their care and leads to unnecessary hospitalizations. Take the example of caring for diabetics. More than thirty million Americans have diabetes, the product of our ever-increasing girth and sedentary lifestyle. Over 60 percent of Medicare spending goes toward patients with chronic conditions like diabetes and heart disease, and the majority of the money is spent on hospitalizations for complications that could have been prevented with proper care. But keeping diabetics out of the hospital requires constant monitoring. Diabetics who fail to control their blood sugar are more likely to go blind, suffer heart attacks, or have a leg amputated because of a wound that won't heal. Preventing those complications isn't rocket science; it just takes constant work. Patients need to learn to eat better and exercise. They need to monitor their blood sugar and take their insulin or other drugs. They need to see an ophthalmologist regularly to check for damage to the retina and a podiatrist to ensure they are caring for their feet. And their doctors need to check their hemoglobin on a routine basis to make sure they are controlling their blood sugar at home. How often does all of this coordinated care actually happen? Outside of a few systems, like the VHA, Group Health, and Kaiser, rarely at best. Let's look at just one piece of this puzzle, monitoring hemoglobin. If you have diabetes, your chances are about one in four that a doctor will actually perform that test, let alone teach you to check your own blood sugar level on a regular basis. According to a recent RAND Corporation study, failing to get their blood sugar checked leads an estimated twenty-six hundred diabetics to go blind every year and another twenty-nine thousand to experience kidney failure. Doctors and hospitals don't neglect to treat diabetics properly because they are lazy or incompetent or don't care about their patients. They fail to do it in part because the payment system punishes them financially when they do. About seven years ago, a group of idealistic doctors in Bellingham, Washington, a bucolic coastal town about an hour north of Seattle, created Pursuing Perfection, a program to help participating medical practitioners prevent diabetes and chronic heart failure and to better care for patients who already have the conditions. The program centers on multidisciplinary teams employing the best practices for counseling patients, helping them to navigate the health care system and control their diseases. It also calls for preventive measures, providing access to nutritionists and nurses to help patients learn to eat better and exercise more in order to avoid getting the conditions in the first place. The doctors have implemented information technology to allow everyone involved in a patient's care to share medical records and support disease management. Pursuing Perfection has already improved the health of many patients. Rebecca Bryson suffers from both diabetes and congestive heart failure. Before enrolling in the program she was seeing fourteen different doctors and taking forty-two medications. When her lungs would fill with fluid from her congestive heart failure, she would call a doctor's office and tell the nurse what was happening. Sometimes she would get a call back in an hour, sometimes not for a day. She landed in the emergency room routinely. Under the new plan, she has access to a nurse, called a clinical specialist, who knows her case intimately, helps her adjust her medic actions, and gets her in to see the doctor when she needs it. Bryson also has access to her own electronic medical record, where she can note reactions to a new medication. With the help of her clinical specialist, Bryson has learned how to avoid

OVERTREATED 280

going to the doctor by doing things like checking on the salt in her diet if her blood pressure goes up. These simple steps have had measurable results for patients across the board, reducing blood sugar levels in diabetics and preventing crises in heart failure patients. Pursuing Perfection has not only improved the lives of patients like Rebecca Bryson, it is saving both Medicare and private insurers thousands of dollars per patient and could cut deaths from diabetes by half. But Pursuing Perfection is killing the local hospital. Between 200 I and 2008, the initiative will have cost Peace Health's St. Joseph Hospital, in Bellingham, $7.7 million in lost revenue because patients aren't being admitted as often. The county's specialists stand to lose $ 1.6 million from lost procedures and office visits, and from having to spend time with patients without being compensated. Insurers won' (pay for a nutritionist to teach diabetics how to eat properly. They pay podiatrists well to perform procedures, but not to help a diabetic learn to inspect his own feet. One group of sixty doctors, at the Madrona Medical Group, who took part in planning the initiative, have withdrawn from the program because participating will cost them too much money. This is the sorry state of American health care. Doing what's best for patients is bad for business. The problem here is not that there's no money; it's that the money flows through the system in the wrong way. Hospitals are paid for each episode of care, each hospitalization, and doctors are paid for each office visit, each procedure. They aren’t paid to coordinate the care of diabetics or heart failure patients, to hire nurses to track a patient ‘s weight or make sure his lungs aren’t filling up with fluid, or a nutritionist to help a diabetic understand what she can and cannot eat. In order for programs like Pursuing Perfection to succeed, hospitals must work with all local doctors, not just those who are willing to lose money in order to help their patients. The way to do that is to pay them as if they were a single, integrated group, hospitals and doctors working together. But that’s not how we do it. Instead, our insurers pay the hospital one fee and the individual contractors who work in it—the doctors-another. Medicare officials are well aware that their own payment system is working against the health of patients, and they have proposed a solution to the problem of poor quality called “pay for performance,” or “P4P.” In phase one, hospitals receive a small bonus for monitoring their own performance on seventeen measures of quality. Most hospitals are now checking such things as what percentage of diabetics receive an eye exam once a year and how often heart attack patients are given instructions to take aspirin or a prescription for beta-blockers. More performance measures will be added to the list as the plan progresses. In phase two, hospitals will be paid another small bonus for actually improving their scores on each measure. Hospitals that are below average will eventually be fined. Medicare is also test-driving a similar plan to measure the performance of Individual physicians. Doctors fear that they will be measured on things they can’t always control. Say a physician has a group of diabetics, for instance, and she's taking great care of them, monitoring their blood sugar regularly and helping them stay out of the hospital. But one of her patients simply won't do what's necessary to keep himself healthy. He refuses to measure his blood sugar. He doesn't take his insulin. And he eats anything he wants, no matter how his doctor exhorts him to change his ways. When Medicare then measures that doctor's performance, she may look bad because of one recalcitrant patient. It's also difficult to measure an individual doctor's performance because patients move between doctors so often, and they see multiple specialists, making it difficult to assign responsibility for an individual patient to a single primary care physician. But the larger reason we shouldn't be measuring individual doctors is that it doesn't foster cooperation among them. Medicare'sP4P plan for hospitals won't either, because it focuses too narrowly on individual aspects of a web of events that must happen in order for a hospital to care properly for a patient. Focusing on a few discrete measures is like saying you are going to make a building earthquake-proof by bolting the furniture to the floor, or reform Social Security by switching to a cheaper brand of ink for writing the checks. The question is, how can we move the five thousand hospitals and eight hundred thousand physicians in this country to organize themselves into cooperative groups? One way to do it would be to allow the VHA to take over failing hospitals. My colleague Phillip Longman, in his book Best Care.

120 (6)

Supreme Court, U.S.
FILED

FEB 13 2009

OFFICE OF THE CLERK

No. 08-543

In the
Supreme Court of the United States

LAWRENCE R. POLINER, M.D.,
LAWRENCE R. POLINER, M.D., P.A.,
Petitioners,

v.

TEXAS HEALTH SYSTEM, doing business as
Presbyterian Hospital of Dallas Texas, a Texas
non-profit corporation, JAMES KNOCHEL, M.D.,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

PETITION FOR REHEARING

LAWRENCE R. POLINER, M.D., F.A.C.C.
7777 FOREST LANE, C600
DALLAS, TX 75230
(972) 566-8477

Petitioner Pro Se

February 13, 2009

Becker Gallagher · Cincinnati, OH · Washington, D.C. · 800.890.5001

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES ii

PETITION FOR REHEARING 1

CONCLUSION 3

CERTIFICATION 4

TABLE OF AUTHORITIES

RULES

Sup. Ct. R. 44 4

PETITION FOR REHEARING

As a physician on behalf of patients and my fellow citizens, I humbly petition that the Honorable Justices of the United States Supreme Court reconsider ruling on the interpretation of law found in the Health Care Quality Improvement Act (HCQIA) to provide quality assurance to improve patient care.

All hospitals review care so that any deficiencies can be corrected to improve quality for patients. Analysis of care a physician provides to his patients is called peer review. Doctors need a protected environment so they may freely evaluate patient care. Administrative action may be taken to improve care. Hospital bylaws provide process. The legal immunity for peer review is provided by HCQIA. To protect patients and those involved in review including physicians whose patient care is reviewed, reasonable belief in the substance of care was required in the words of the Act. HCQIA also created the National Practitioner Data Bank to prevent bad doctors from traveling from place to place harming patients. Doctors who have removal of hospital privileges must be reported to the Data Bank as there is federally required reporting and interrogation by all hospitals for all physicians. The Data Bank report of loss of hospital privileges is meant to prevent a physician from holding those hospital privileges anywhere and can end a physician's career.

Patients and all citizens under the substance and intent of HCQIA have a right to quality assurance that is performed in the reasonable belief of veracity to improve their care. The ruling by the U.S. Fifth Circuit Court of Appeals holds that this obligation may be carried out with a *knowledge* that the allegations are *not true* and for *any motive*; and accords, in effect, a grant of absolute federal immunity for this act. The elimination of all evidence of malice and motivation from consideration by a jury by an act of federal law is a misinterpretation of HCQIA. This ruling quite simply gives license to malicious fraudulent allegations for any ulterior motive in the name of "patient care" and accords federal immunity.

HCQIA, in its intent and meaning, constitutes an obligation to patients and citizens by federal courts to uphold the law. Actions under HCQIA are **qualified** by the requirement of a "reasonable belief" which Congress defined as more objective than requiring "good faith". The Fifth Circuit interpretation holds that federal immunity is granted for being "objectively reasonable" that an assertion is about "patient care" and that all evidence of malice and motive by being labeled "subjective" are legally irrelevant. As a result, immunity is not qualified but, in effect, becomes absolute as a matter of law. This destroys the obligation to patients and citizens of the reliability of quality assurance to improve patient care. This is true because under the appellate ruling quality assurance does *not* need to be honest and can be carried out for any motive and no evidence to the contrary is relevant. Such an interpretation undermines and completely reverses the intent of HCQIA to assure quality for patients.

The reliability of quality assurance for patients affects everyone. The current interpretation of HCQIA by the Fifth Circuit will remove rights and protection under the law from citizens. Patients will not be able to trust that quality assurance is to improve their care. Physicians may be subjected to malicious review for any motive because it is about patient care with devastating effect. Those responsible for such acts are protected by federal immunity by hiding behind the words "patient care" and "peer review". HCQIA can only provide citizens with assurance of health care quality improvement if there is **qualification** by evidence. Protection otherwise is assured to those whose intent and motive is not patient care, but cannot be assured to physicians in acting to protect patients. Elimination of all evidence of abuse by law only serves to harm the very thing the law was meant to protect—patient care.

Quality assurance and peer review need a doctor. The meaning of HCQIA needs to be revived. The Court has the opportunity by ruling to assure for patients and society the standard of quality required by those who health care serves.

CONCLUSION

For the reasons stated above, this Court should consider the grant of the petition for a writ of certiorari.

Respectfully submitted,

Lawrence R. Poliner, MD, FACC
7777 Forest Lane, C600
Dallas, TX 75230
(972) 566-8477

Petitioner Pro Se

Dated: February 13, 2009

CERTIFICATION

The foregoing is restricted to the grounds specified in 44.2 Sup. Ct. R. and it is presented in good faith and not for delay.

Lawrence R. Poliner

Lawrence R. Poliner, M.D., F.A.C.C., *pro se*